Illinois Department of Public Health

HUMAN SERVICES PLAN
1992-1994

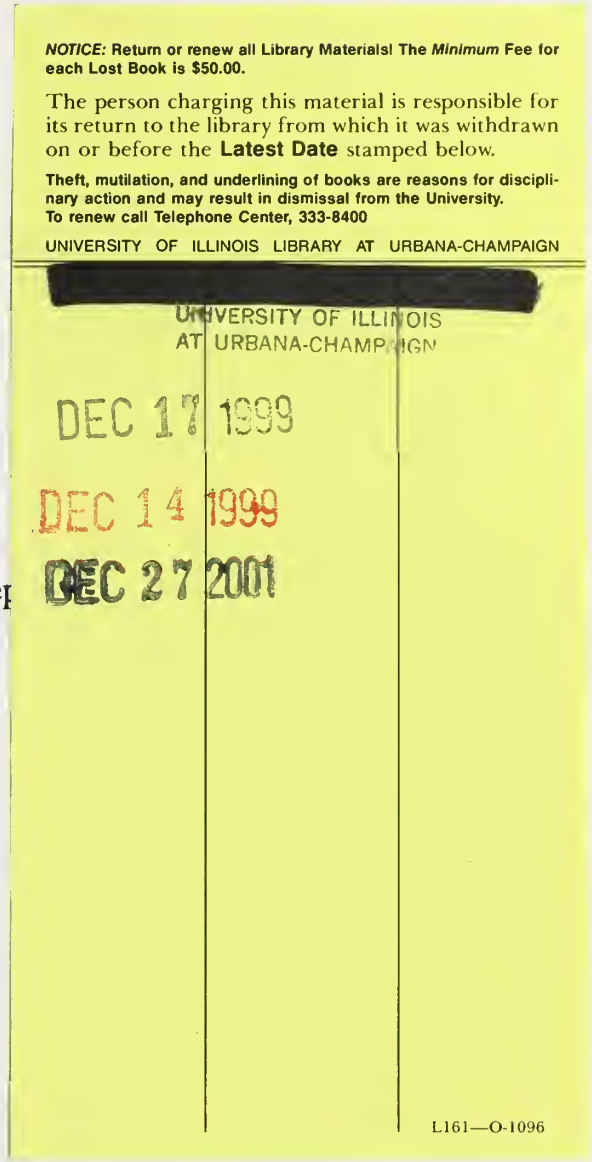
DATA REPORT
VOLUME 7

1992–1994 HUMAN SERVICES PLAN

ILLINOIS DEPARTMENT OF PUBLIC HEALTH

John R. Lumpkin, M.D.

Director



Part I

Human Services Data Rep

Volume 7

December 1994

Prepared in Accordance with Public Act 79-1035

Printed by the Authority of the State of Illinois

500 Copies

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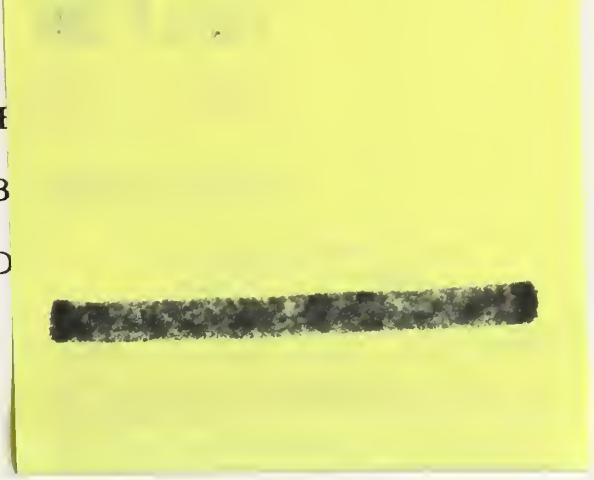

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Illinois Department of
Public Health

John R. Lumpkin, M.D., M.P.H., Director

525-535 West Jefferson Street • Springfield, Illinois 62761-0001

December 1, 1994

TO THE HONORABLE MEMBERS OF THE ILLINOIS GENERAL ASSEMBLY:

I am pleased to present to you the Illinois Department of Public Health's ***1992–1994 Human Services Plan—Part I, Data Report.*** This plan describes the activities and services provided by the Department over the past several years and describes expenditures for those fiscal years.

The plan is organized according to 1992–1994 major goals. That is, all program activities addressing the same goal have been discussed together in a single section. More importantly, this organization clarifies the interrelationships between various Departmental programs and puts the focus of the plan on improving the health of Illinoisans. The Department's programs include Community Health, Health Protection, Health Care Regulation, Epidemiology and Health Systems Development, Finance and Administration and the Center for Rural Health.

Chapter I describes the results of a statewide health needs assessment endorsed by the State Board of Health in September 1993. In fiscal year 1995, the Department will continue development of a state health plan to meet the *Healthy People 2000* national health objectives.

Written public comment on this document will be received during the months of December and January. Any changes resulting from such comments will be presented to you in a plan addendum.

Respectfully,

John R. Lumpkin, M.D.
Director of Public Health

AGENCIES PARTICIPATING IN HUMAN SERVICES PLANNING

Volume 1 Department of Children and Family Services*
406 E. Monroe
Springfield, Illinois 62701

Volume 2 Department of Public Aid*
100 South Grand Avenue East
Springfield, Illinois 62762

Volume 3 Department of Corrections*
Executive Office Building
1301 Concordia Court
Springfield, Illinois 62794-9277

Volume 4 Department of Rehabilitation Services*
623 East Adams
P.O. Box 19429
Springfield, Illinois 62794-9429

Volume 5 Department of Alcoholism and Substance Abuse*
100 West Randolph Street
Suite 5600
Chicago, Illinois 60601

Volume 6 Department on Aging*
421 East Capitol Avenue, #100
Springfield, Illinois 62701-1789

Volume 7 Department of Public Health*
535 West Jefferson Street
Springfield, Illinois 62761

Volume 8 Department of Employment Security*
401 S. State
6 South
Chicago, Illinois 60605

Volume 9 Department of Commerce and Community Affairs
620 East Adams
6th Floor
Springfield, Illinois 62701

Volume 10 Department of Human Rights
100 West Randolph
Suite 10-100
Chicago, Illinois 60601

Volume 11 Department of Veterans' Affairs
833 S. Spring Street
Springfield, Illinois 62704

Volume 12 No longer available. Formerly Commission on Delinquency Prevention Youth Services, which was consolidated in the Department of Children and Family Services.

Volume 13 Division of Services for Crippled Children
University of Illinois
2040 Hill Meadow Drive, Suite A
Springfield, Illinois 62702-4698

Copies of individual plans may be obtained directly from each agency listed above.

*These agencies are mandated by Public Act 79-1035 to produce Human Services Plans.

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INTRODUCTION

Purpose

The Illinois Department of Public Health has a broad range of responsibilities for the promotion and protection of health and the prevention of diseases among Illinois residents. This ***1992–1994 Human Services Plan (HSP)—Part I, Data Report***, contains information about the Department's programs, services and budget. It is prepared according to the requirements of the Illinois Welfare and Rehabilitation Services Planning Act. This report includes significant events that occurred in fiscal year 1994.

Fiscal Year 1994 Highlights

- The Department doubled to $7.1 million its General Revenue Funds for AIDS education, prevention and direct services. Monies were allocated to medical care, expanded counseling and testing services and increased prevention and educational efforts targeted at high risk and minority segments of the population. A major component of this increase was allocated for an increase in both eligibility and in the number of drugs available through the AIDS Drug Reimbursement Program.

- The Department expanded services for maternal and child health by targeting case management and outreach services. Interagency implementation of the Healthy Moms/Healthy Kids initiative allowed the Department to provide services to people who have incomes less than 185 percent of the federal poverty level, but who are not eligible for Medicaid through the Department of Public Aid. Healthy Moms/Healthy Kids and the Healthy Start initiative allowed the Department to provide case management and outreach services to three times the number of clients previously served.

- The Healthy Start initiative is charged with reducing infant mortality by 50 percent within six designated areas in Chicago. More than $4 million in federal funds were used to expand case management, primary care and support services, outreach and follow-up, and economic development in these designated areas.

- Grants to local health departments (LHDs) for basic health protection and prevention activities were $8.8 million in fiscal year 1993 and $8.9 million in fiscal year 1994. In addition, monies were available to fund new LHDs approved by voter referendum at the last election and two existing developmental health departments that were certified.

- The Department and LHDs throughout the state significantly expanded their screening for lead poisoning among children. Laboratory testing by the Department increased by 50 percent, allowing 120,000 children to be tested in fiscal year 1994.

- Project Cornerstone—a management information system (MIS) designed to integrate program enrollment, processing and reporting—will provide a single point of entry with a common enrollment procedure for several maternal and child health programs including WIC (the federal Special Supplemental Food Program for Women, Infants and Children), immunization, prenatal care, pediatric primary care and case management. Demographic and eligibility information specific to a client will be captured once and

shared with all other service providers who are participating in Cornerstone and are caring for that client. The Cornerstone MIS will be installed, first, in the Chicago Healthy Start Project Area and then in the remaining 350 maternal and child health service sites throughout Illinois.

Organization of Human Services Plan

Chapter I of this plan provides an overview of the *Statewide Health Needs Assessment: Towards a Healthy Illinois 2000*. Chapters II through VI contain program descriptions organized by office within the Department. Chapter VII describes the organization and functions of the Office of the Director.

The Department receives funding from a wide range of state and federal sources. Appendix Tables A-1 through A-37 display appropriations and expenditures for all sources for the Department, each of its offices and their divisions for fiscal years 1990 through 1994 and the budget requested for fiscal year 1995. Appendix Tables A-38 through A-40 display each federal funding source by program title, administering agency, statutory reference and required state match.

Assessment of Public Health

The primary functions of governmental public health agencies are assessment, policy development and assurance as described by the 1988 Institute of Medicine (IOM) report, *The Future of Public Health*. The assessment function, according to the IOM, requires the regular and systematic collection, assembly, analysis and reporting of data and information on health needs of the community. Assessment must address not only previous or present status, but also must predict, based on sound analytical and research methods, future needs for which policy must be developed.

The IOM recommends that every public health agency should exercise its responsibility to serve the public interest in the development of comprehensive public health policies by promoting use of the scientific knowledge base in decision making and by providing leadership. Policy formulation is the process by which society selects problems to address, chooses goals and the proper means to reach them, handles conflicting views, takes appropriate action and allocates resources.

Public health agencies must, according to the IOM, assure provision of services necessary to achieve agreed upon goals, by encouraging actions of private or other public entities, by requiring such action through regulation or by providing services directly. Every public health agency must involve key policymakers and the general public in determining a set of high priority personal and community-wide health services that governments will guarantee to every member of the community. This guarantee should include subsidization or direct provision of high-priority personal health services for persons unable to afford them.

Illinois' public health community underwent a comprehensive self-assessment during the last several years. This effort, Project Health, was sponsored by the Department, the Illinois Association of Boards of Health, the Illinois Association of Public Health Administrators, the Illinois Public Health Association and the University of Illinois School of Public Health. This group led the way in redefining the role of governmental agencies in the public health system to meet the mission of public health: to assure conditions in which people can be healthy.

Project Health made 36 recommendations that redefine the relationship between the state and LHDs. The Department adopted by rule, a new certification process for LHDs based on the implementation of core functions described above. These applied components of core functions are known as practice standards. The Department conducted a statewide health needs assessment and will continue development of a state

health plan based on a comparison of Illinois data with *Healthy People 2000* national objectives. The state provided leadership in assisting LHDs in conducting needs assessment and developing community plans. Community health needs assessments and plans were completed by June 30, 1994.

The statewide health needs assessment results are described in Chapter I and the overall process of assisting LHDs (Illinois Project for Local Assessment of Needs) is detailed in the Chapter V description of the Health Policy program.

Organization of Department

To carry out its mission, the Department is organized into five administrative offices. These five offices—Epidemiology and Health Systems Development, Community Health, Health Care Regulation, Health Protection, Finance and Administration—and their divisions are displayed in the organizational chart (Figure 1). Department staff are based at two central offices (Springfield and Chicago), seven regional offices and three laboratories. Figure 2 is a map of the Department's seven regions showing the location of regional offices and three laboratories.

Fiscal Years 1992 through 1995 Budgets

The Department's fiscal year 1993 budget ($379.1 million) is 1.9 percent higher than fiscal year 1992 ($372.1 million). Approximately one fourth of the budget is General Revenue Fund (GRF). Fiscal year 1993 GRF ($95.8 million) is 18.4 percent lower than fiscal year 1992 ($110.2 million). Although the 1993 fiscal year budget severely decreases GRF money, it adds appropriations for five new funds in fiscal year 1993 totaling $4.4 million: Lead Poisoning, Screening, Prevention and Abatement; Nurse Dedicated and Professional; Plumbing Licensure and Program; Ryan White AIDS Victim Assistance; and Tanning Facility Permit. (See Appendix Tables for budget-related detail for fiscal years 1990 through 1995).

Public Comment

Public comment on this plan is welcomed and may be made in writing to the following address:

Illinois Department of Public Health
Office of Epidemiology and Health Systems Development
525 West Jefferson Street
Springfield, Illinois 62761

To be considered, comments must be received no later than 5:00 p.m., January 30, 1995. All comments received by this date will be carefully reviewed. Changes to this plan that result from public comment will be published under separate cover.

Legal Citations

Illinois Welfare and Rehabilitation Services Planning Act, 20 ILCS 10/1 *et. seq* (Ill. Rev. Stat. 1991, ch. 127, ¶ 951 *et. seq.*)

Figure 1

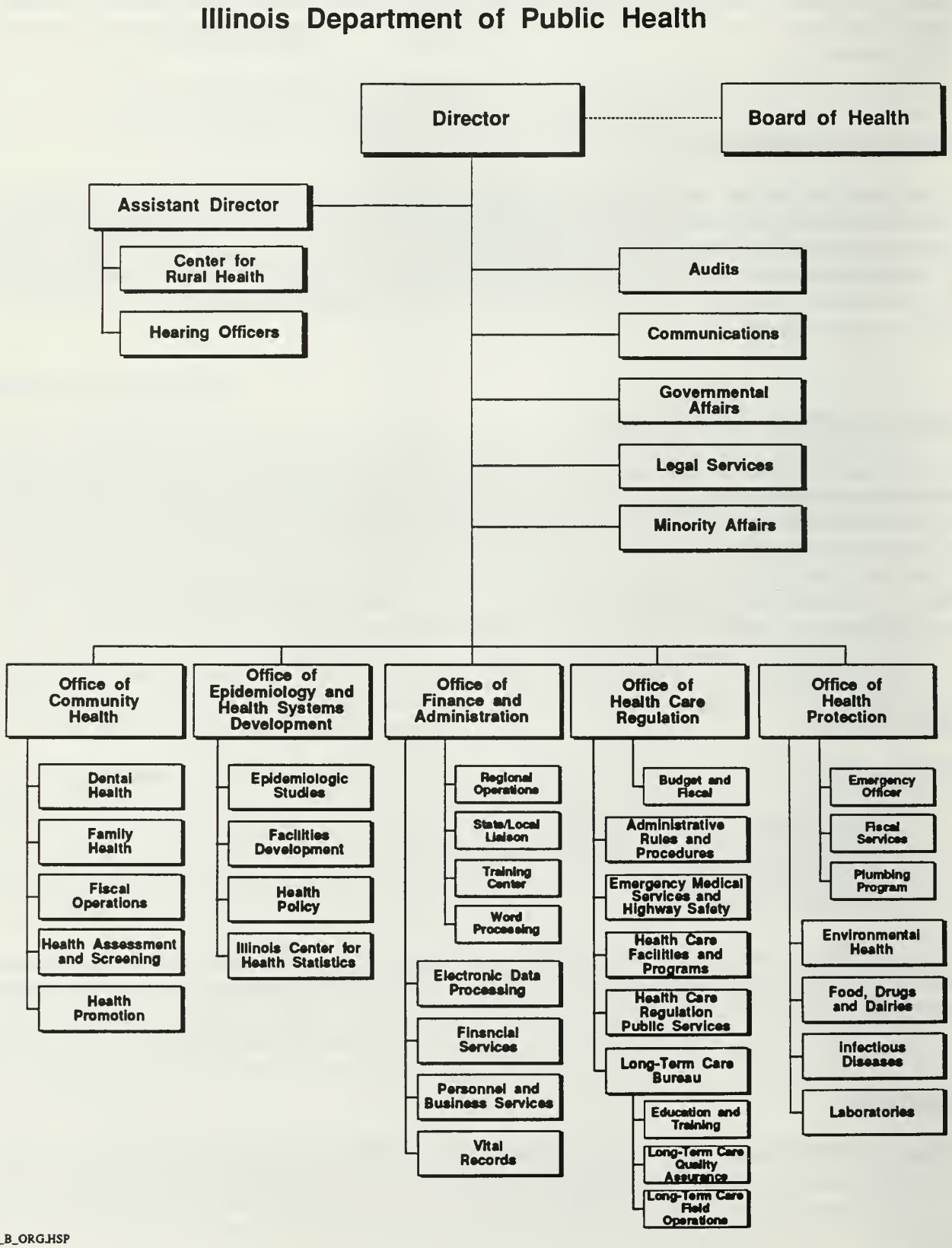

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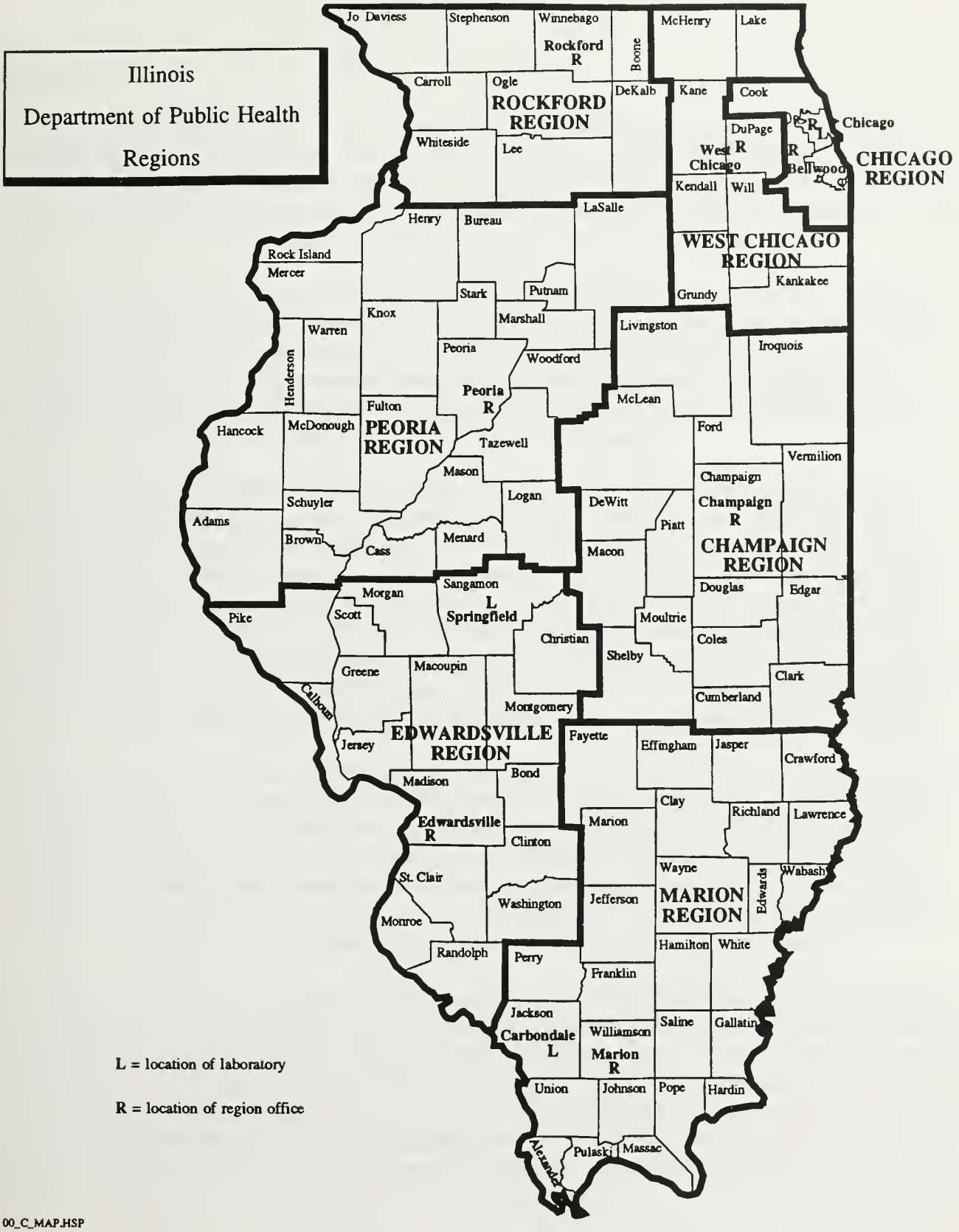
Figure 2



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CHAPTER I

ILLINOIS PUBLIC HEALTH PRIORITIES

Introduction

The mission of the Department is to promote health through the prevention and control of disease and injury (adopted June 1994). Governmental public health agencies have a specific responsibility to ensure that a system is in place to allow the public health mission to be achieved. The Department has taken a leadership role in redirecting the Illinois public health system to focus on achieving successful implementation of the core public health functions of assessment, policy development and assurance of services.

Project Health, a four-year effort involving state and local public health agencies along with public health academia, defined and negotiated implementation strategies for an improved public health system in Illinois. One of Project Health's major recommendations is that statewide and local needs assessments be conducted to provide accurate, concise and defensible information to identify and describe public health needs. The participants in Project Health agreed that needs assessments in Illinois should have a standardized structure of content elements which were intended to form a minimum assessment.

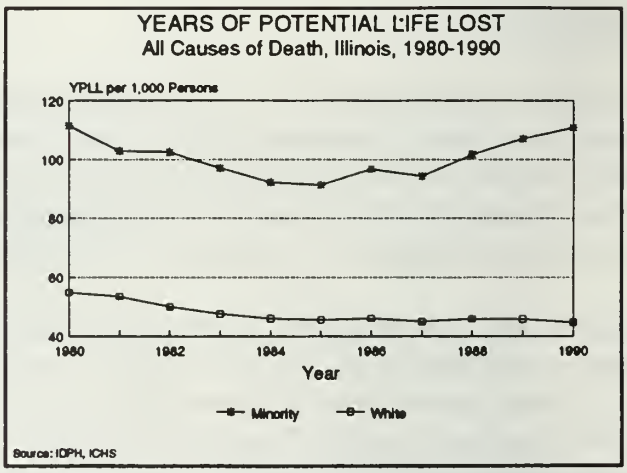
Using this standardized data set, Department staff developed a statewide health needs assessment. After major health problems were assessed, the senior staff of the Department held a mini-retreat in late September 1992 to review the assessment and establish public health priorities. These priorities were established using both quantitative and qualitative methods. Objective criteria were developed by the group and applied to the universe of health problem statements in the assessment. These criteria addressed the size and severity of the problem and the availability of an effective public health intervention to reduce the problem. Qualitative input was incorporated, focusing on perceptions of political and financial feasibility of an aggressive public health response to the problem. The Department believes this process of ranking problems and setting priorities, although challenging, has resulted in a more comprehensive set of health priorities for Illinois.

Each priority and related problem is briefly described below with a statement of findings from the assessment and, where useful, a chart illustrating the Illinois problem in relation to the *Healthy People 2000* national health objective. There are 10 health status priorities and six priorities of an overarching nature. The overarching priorities in many cases have a direct effect on the interventions necessary to reduce the priority problems. The 10 health status priorities are closely related to the first overarching priority. In the following discussion, therefore, the first overarching priority is followed by a description of the 10 health status priorities. The remaining five overarching priorities are described at the end of this section.

It should be noted that the comparisons of Illinois data to U.S. data contained in this report are intended to inform the reader of Illinois' standing among the states. Comments on Illinois' data with respect to *Healthy People 2000* objectives are intended to present a measure of progress toward specific health goals. These comparisons and references to *Healthy People 2000* objectives should not be construed to indicate that acceptable levels of health problems exist. For example, a rate of incidence that is lower than the national rate may indicate that the State is doing comparatively better than the U.S., but the U.S. rate may be high compared to other nations. Any level of disease or injury may need to be addressed as a public health concern.

Overarching Priority: White-Minority Health Status Disparities

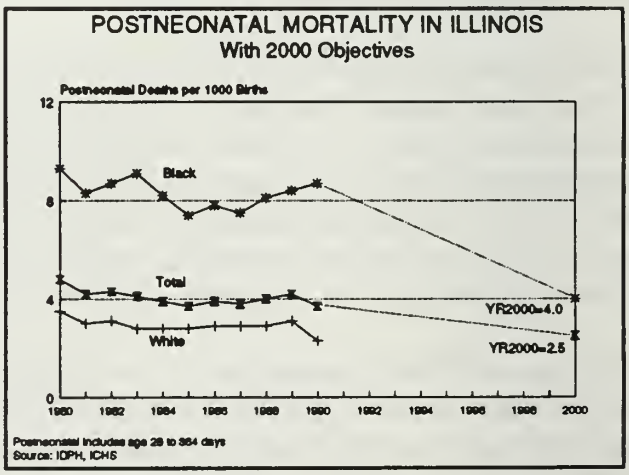
A severe disparity exists between Illinois' white and minority populations in rates of premature mortality (death at ages younger than 65 years). Between 1980 and 1990, the life expectancy for African-Americans dropped slightly.



Using the white Illinois mortality rate as a basis for comparison, one-fourth of the non-white deaths in Illinois in 1990 were in excess of the expected number. For the minority population younger than age 65 years, actual deaths were almost 50 percent higher than the number expected. While the life expectancy of the white population in Illinois increased, the life expectancy of Illinois African-Americans decreased slightly from 67.6 to 67.3 years between 1980 and 1990. Premature mortality is often measured as years of potential life lost. Causes of years of potential life lost in the African-American population are perinatal conditions, homicide, firearms, unintentional injuries, heart disease and cancer. All these causes can be either prevented or substantially reduced with effective public health interventions. Many of these causes and other health problems that involve large white-minority disparities are discussed below as specific priorities. Most public health researchers and practitioners have found poverty to be a key determinant of poor health outcomes. Unfortunately, data are generally not collected in sufficient detail to directly link socioeconomic status with health outcomes.

Infant Mortality

The 1990 infant mortality rate of 10.7 deaths per 1,000 live births was the lowest rate in Illinois' history. Despite this improvement, Illinois' rate of infant death remains 18 percent higher than the 1990 U.S. provisional rate and 53 percent higher than the "Healthy People 2000" objective of 7 deaths per 1,000 live births.



Overall infant mortality and its two components, neonatal mortality and postneonatal mortality, are declining in Illinois. However, the African-American population is experiencing a much less rapid reduction of neonatal mortality and is actually experiencing an increasing rate of postneonatal mortality. More aggressive public health interventions will be necessary to achieve the *Healthy People 2000* objective for initiation of prenatal care in the first trimester of pregnancy. If at least 90 percent of pregnant women get good prenatal care (as called for in the *Healthy People 2000* objective), the percent of low birth weight births should finally begin to improve in Illinois.

Breast and Cervical Cancer

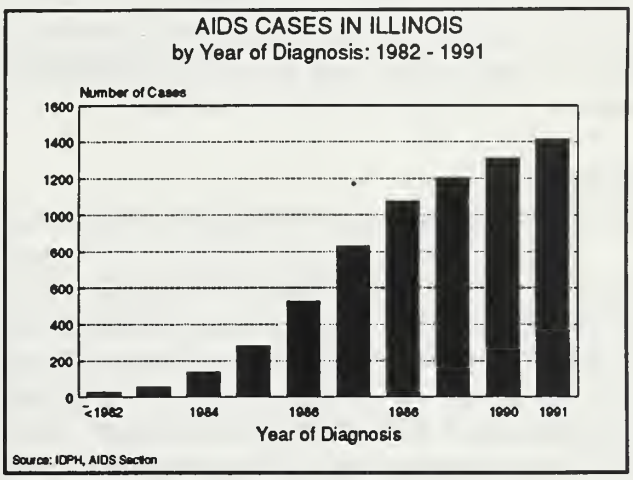
To achieve the "Healthy People 2000" objectives for reducing mortality and improving the stage of diagnosis for female breast and cervical cancer, screening must increase. Incidence of late stage cervical cancer is very high among Hispanic and African-American women, with especially high cervical cancer mortality among African-American women.

Age-adjusted mortality rates indicate no decrease during the 1980s among Illinois women for breast cancer and a 20 percent decrease in age-adjusted rates for cervical cancer. Despite effective methods of screening, only 65 percent of new breast cancer cases in 1990 were diagnosed in early stages of the disease; nearly three-fourths of new cervical cancer cases were diagnosed in the non-invasive stage. The percentage of breast cancer cases diagnosed in early stages needs to increase dramatically to reach *Healthy People 2000* national health objectives. African-American women experience a premature cervical cancer mortality rate twice as high as the rate among white women in Illinois. African-American and Hispanic women are 2.5 times more likely than white women to be diagnosed in the late stages of cervical cancer, when the disease is less curable. The non-use of routine screening such as mammography and Pap tests may indicate insufficient accessibility to primary care services.

AIDS and HIV Infection

Rates for both AIDS and HIV infection are steadily increasing.

Although Illinois rates remain lower than U.S. rates, reported Illinois cases of AIDS and HIV infection increased 22 percent and 11 percent, respectively, from 1990 to 1991. HIV infection rates increased by more than 10 percent in 1991 among women giving birth. The growth in the incidence of AIDS between 1990 and 1991 was primarily due to transmission from intravenous drug use and from heterosexual contact.



Chronic Disease Risk Factors

Reducing the number of smokers, modifying dietary and alcohol intake habits, and increasing physical activity are necessary to bring Illinois mortality rates closer to U.S. rates.

Substantial scientific research indicates that several risk factors controllable by each individual can play an important role in the prevention of cardiovascular diseases, cancers, stroke and diabetes. The Behavioral Risk Factors Survey is administered annually in Illinois. 1990 data indicate that more than 23 percent of Illinoisans report weights that categorize them as overweight for their height. Nearly 24 percent of Illinoisans report they are smokers. More than 61 percent of Illinoisans report they do not regularly engage in leisure time physical activity. The Illinois survey data on each of these risk factors are slightly higher than comparable U.S. data. Survey data for the African-American population show worse levels of overweight and physical exercise, but a slightly lower level of smoking. Substantial improvements in diet, smoking cessation and physical exercise are needed to reach *Healthy People 2000* objectives for these contributors to chronic disease.

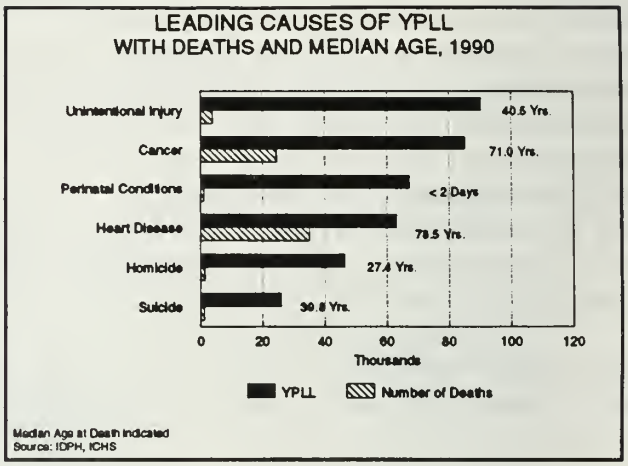
Vaccine Preventable Diseases

There is relatively complete immunization of Illinois children by the time they enter kindergarten, but sample studies for Illinois suggest immunization is not adequate among Illinois 2-year-olds.

According to school records, in both 1990 and 1991, 97 percent of kindergarten children in Illinois received the recommended immunizations, called the basic series. This coverage of 5-year-olds surpasses the *Healthy People 2000* objective of 95 percent. However, sample studies at public provider clinics suggest that 57 percent of 2-year-olds in Illinois outside Chicago have been immunized with the basic series, while only 29 percent of Chicago 2-year-olds have been immunized as recommended. Vaccines provide a reliable and cost-effective measure to prevent illness. A series of immunizations for protection against diphtheria, pertussis, tetanus, measles, mumps, rubella, polio and *Hemophilus influenzae* type b (Hib) should be administered to all Illinois children by the time they reach the age of 2 years.

Unintentional Injuries

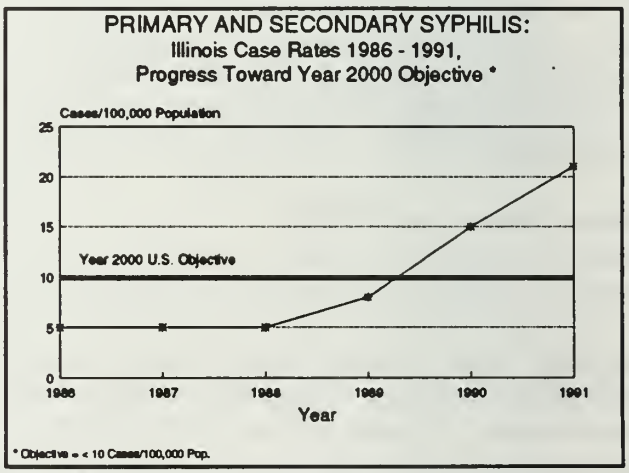
Although unintentional injury in Illinois dropped to the fifth leading cause of death in 1990, it remains the leading cause of years of potential life lost.



Injuries are the leading cause of death for Illinoisans aged 1 through 44 years. Mortality due to injury is usually analyzed by the external cause of the injury. Most are caused by motor vehicle crashes, but many are caused by fires, drownings or falls. For African-Americans aged 15 through 44 years, unintentional injury is the second leading cause of death. Although the Illinois trend is in the right direction, too many die prematurely from these preventable causes.

Syphilis

Reported rates of primary, secondary and congenital syphilis are increasing rapidly.



Although the disease is traditionally underreported, the cases of syphilis in Illinois have increased 366 percent since 1987. Much of the increase has been among African-Americans, with a reported increase in cases of 524 percent since 1987. Between 1990 and 1991 alone, rates of primary and secondary syphilis cases increased 40 percent. The 1991 rate is more than twice the *Healthy People 2000* national health objective. This negative trend over the past five years is especially troubling because it has led to a similarly dramatic increase in the rate of congenital syphilis cases. Congenital syphilis results in a 40 percent to 50 percent mortality rate in infants and fetuses. In addition, syphilis and other sexually transmitted diseases have been shown to facilitate the transmission of HIV infection. Controlling syphilis is essential to prevention of several life-threatening conditions.

Childhood Lead Poisoning

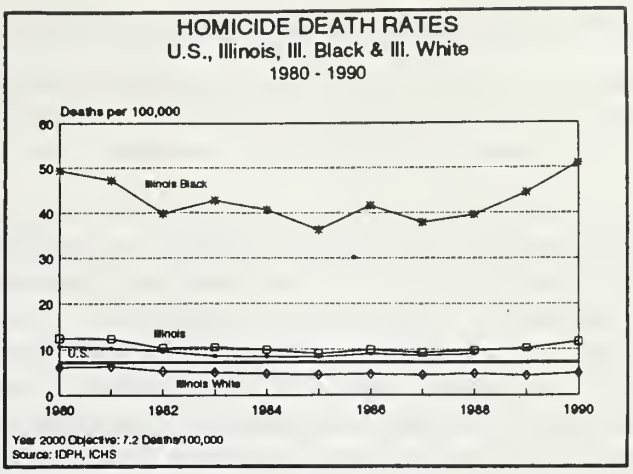
Statewide, more than 33,000 children have been found to have blood lead levels in excess of the Centers for Disease Control and Prevention (CDC) standards. More than 90 percent of these children live in Chicago.

Lead is one of the most serious environmental exposures for children, damaging the developing brain and nervous system. Chronic exposure to low levels of lead has been linked to low levels of intelligence and to impaired growth. In 1992, a comprehensive testing program for lead intoxication in children was initiated. In that year more than 33,000 children, 16.3 percent of those tested, were found to have blood lead levels equal to or greater than 15 µg/dl, and more than 11,000, or 5.4 percent, had levels exceeding 25 µg/dl. As the screening program becomes more established, the number of Illinois children found with lead poisoning is expected to increase.

Homicide

The 1990 homicide rate rose in Illinois, dramatically among African-Americans. The homicide rate in the African-American population is more than ten times the rate in the white population. The Hispanic population also experienced a homicide rate higher than the rate for the non-Hispanic population.

The 1990 age-adjusted mortality rate for homicide is approximately 30 percent higher in Illinois than in the U.S. The homicide death rate for Illinoisans aged 15 through 24 years is 67 percent higher than the U.S. rate. Age-adjusted data indicate only a slight decline in homicide in Illinois between 1980 and 1990. It is, therefore, not clear if Illinois is making progress towards achieving the *Healthy People 2000* national health objective for homicide. It is clear, however, there is a large disparity between the white and African-American population, with the African-American population experiencing especially high homicide rates among those aged 15 through 44 years. Homicide is the leading cause of death for this age group among African-Americans.



Tuberculosis

Tuberculosis (TB) is increasing in Illinois at a rate higher than the national average. Unless this trend is dramatically reversed, Illinois will not achieve the "Healthy People 2000" objective for TB.

After several decades of decline in the incidence of tuberculosis, by the mid-1980s the downward trend stabilized and is now on the rise. Several factors may be causing this increase, including increasing poverty and homelessness, increases in the number of immunocompromised persons vulnerable to TB, and the development of multiple drug-resistant strains of the disease. Incidence of TB in Illinois is increasing more rapidly than in the U.S. Minority populations are disproportionately represented, with large numbers of cases and high TB rates among Asian-American, African-American and Hispanic populations.

Overarching Priority: Access to Primary Health Care

Illinois has been unable to decrease its number of Health Professional Shortage Areas (HPSAs) and has held a longstanding low national ranking of percentage of the population residing in HPSAs.

Illinois lags behind other states in adequate numbers and distribution of primary care health professionals. In 1990, Illinois ranked third in the U.S. in total population residing in federally designated primary care HPSAs. There has been no change in this unenviable ranking since 1980. More than 15 percent of Illinois residents live in HPSAs, while 14 percent of the U.S. population does. The lack of primary care can be illustrated in many of the health status priorities representing conditions that are controllable with routine effective primary care.

Overarching Priority: Access to Basic Public Health Services

Eleven Illinois counties with a total population of approximately 471,000 are unserved by a local health department (LHD), and thus lack comprehensive public health services.

An LHD, through a local board of health, gives a community greater control over public health programs such as control of infectious disease, protection from involuntary exposures to environmental hazards, and the reduction of morbidity and premature mortality through prevention and risk reduction. The counties of Carroll, Champaign (part), Clark, Clinton, Edgar, Edwards, Madison, Moultrie, Richland, Scott and Warren are unserved by LHDs. Several of these unserved counties are also designated as primary care professional shortage areas.

Overarching Priority: Prevention and Treatment of Alcohol and Drug Abuse

Alcohol and other drug abuse have significant influence on the health status of the general population. Unless these problems are addressed through comprehensive and accessible treatment programs, many other efforts to improve the health of the population of Illinois will prove less than fully effective.

Alcohol and other drug abuse are significant contributors to poor health outcomes. Alcohol and other drug abuse negatively influence infant mortality and child abuse and neglect rates; contribute to the incidence of birth defects; play a role in motor vehicle and firearms deaths; are important factors in the transmission of HIV infection; and may also figure significantly in environmental, occupational and unintentional injuries. Alcohol and other drug abuse sometimes render their victims unemployable—thereby contributing to the ranks of the uninsured who suffer restricted access to primary health care services. Waiting lists for publicly-funded alcohol and drug abuse treatment programs consistently number in the thousands, and access is further limited for the working poor, who neither qualify for Medicaid benefits nor have private insurance through their employers to pay for treatment. Comprehensive and accessible alcohol and drug abuse treatment programs are essential to ensuring the effectiveness of public health interventions designed to address a variety of public health problems in Illinois.

Overarching Priority: Quality of Health Care Services

The assurance of health care services delivered with high standards of quality is a continuous need throughout Illinois.

There is a wide range of quality in the delivery of health care services in Illinois. Patients of health care facilities and programs generally lack the knowledge required to independently evaluate the quality of care they receive, especially when a medical crisis occurs. This lack of evaluative knowledge, coupled with the structure of the health care marketplace where shopping for care is not routinely done, has led to the existence of few clear and objective measures of quality. Interventions to reduce levels of illness and mortality for priority health problems, however, rely on the effective delivery of health care services. Improvements in quality producing better individual health outcomes should be continuously implemented by health care providers, regulators and consumers.

Overarching Priority: Integrated, Comprehensive Data Systems

Public health surveillance systems must be developed to monitor progress towards achievement of "Healthy People 2000" national health objectives.

Health data sets have been established and maintained by many state agencies for a variety of purposes, including program management and administration, billing and reimbursement, and surveillance of health conditions. The compelling need to develop more effective programs to respond to complex health problems carries an equally compelling need to develop adequate, accessible and organized data sets to support those programs. To increase the utility of data, efforts must continue that develop ways to expand and integrate data sets into larger, more powerful descriptive and analytic tools for policy makers, planners and program managers.

The complete needs assessment is reported in *Statewide Health Needs Assessment: Towards a Healthy Illinois 2000*, published by the Illinois Department of Public Health in September 1993.

CHAPTER II

OFFICE OF COMMUNITY HEALTH

Introduction

Mission

To enhance the quality of life and prevent premature death, disability and disease through health promotion initiatives.

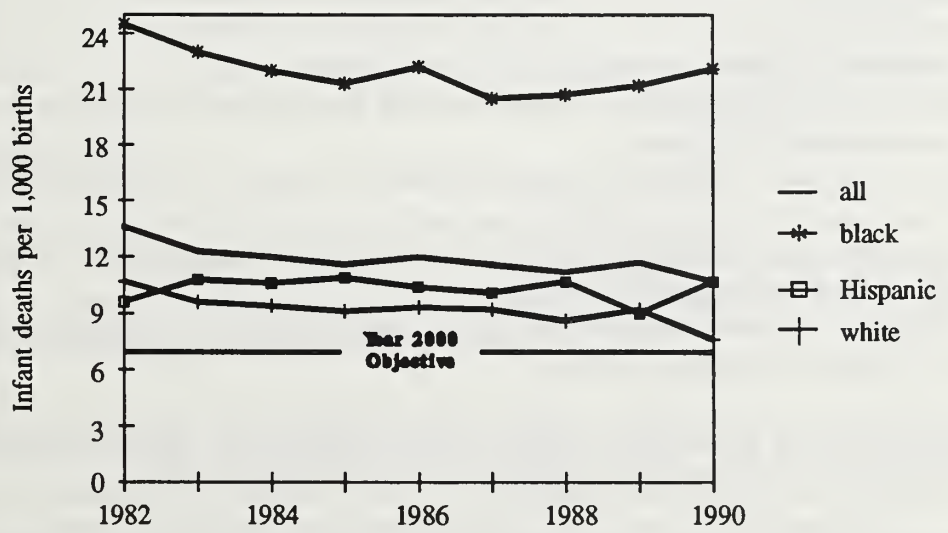
Summary of Responsibilities

Program Overview

The maternal and infant health programs continue to strive toward the *Healthy People 2000* national health objective for infant mortality: a rate of 7 deaths per 1,000 live births. The Illinois infant mortality rate has improved overall, falling from 11.7 in 1989 to 10.8 in 1991 (Figure 1). However, maternal and child health indicators have not improved in minority populations. Resources and programs must continue to target populations at greatest risk. Services that impact infant mortality include prenatal care, case management, perinatal care, genetic screening and counseling, nutrition services and family planning.

Figure 1

Infant Mortality in Illinois
1982–1990



Source: IDPH, Division of Family Health

Children are at special risk for preventable health problems such as unintentional injuries, homicide, child abuse and neglect and lead poisoning. Programs that focus on abating health challenges for children include nutrition services, primary pediatric care, lead screening and follow-up, vision and hearing screenings, dental health, early intervention and school health.

The major preventable health concerns of adolescents are injuries and violence and the development of high-risk behavior related to diet; exercise; sexual practices; safety habits and tobacco, alcohol and drug use. The adolescent health programs have expanded their focus to provide a spectrum of coordinated health care services to meet the needs of adolescents.

In 1990, the leading cause of deaths to Illinois residents was heart disease followed by malignant neoplasm and cerebrovascular disease. Programs for adults promote healthy lifestyle choices targeting chronic diseases, cardiovascular disease, breast and cervical cancer, poor nutrition, inadequate physical fitness and activity, tobacco use, alcohol and drug use, unintentional injuries and violent and abusive behavior.

Methods of Carrying Out Responsibilities

The Office of Community Health awards funds to local agencies for direct services and provides standards and guidelines, compliance monitoring, training and technical assistance. Through standards and guidelines for quality assurance, program and clinical practice standards and "best method" policies are defined and implemented. Compliance monitoring assures that agencies conform to appropriate program and fiscal practices. Local agencies receive training and technical assistance from professional staff who provide support, guidance and up-to-date information about procedures and practices.

Priorities

Comprehensive strategies address the special health problems of infants, children, adolescents, adults and older adults while promoting the health status and integrity of families in Illinois.

To reduce infant mortality, morbidity and developmental disabilities, the Office of Community Health focuses on the following activities:

- reduce the incidence of low birthweight
- increase the proportion of pregnant women who begin prenatal care in the first trimester and who receive case management services
- increase the proportion of pregnant women and infants who receive risk-appropriate perinatal health care
- reduce pregnancies and rapid repeat pregnancies among teenagers younger than 18 years of age and unintended pregnancies among all women
- identify pregnant substance abusing women and provide enhanced case management services
- increase participation in nutrition services

To prevent illness and injury and thereby reduce mortality, morbidity and disability among children and adolescents, the Office of Community Health focuses on the following activities:

- promote positive lifestyle choices regarding diet; exercise; sexual practices; and tobacco, alcohol and drug use
- reduce the prevalence of elevated blood lead levels

- reduce deaths due to unintentional and intentional injuries including deaths due to motor vehicle crashes, drownings, fires and burns, homicides and suicides
- increase the proportion of children who receive primary care services
- increase the number of children in compliance with immunization recommendations
- increase participation in nutrition services
- detect and treat eye and ear disorders and diseases
- prevent and control oral disease

To reduce morbidity and mortality among adults due to chronic diseases that are preventable or controllable or due to violent and abusive behavior, the Office of Community Health focuses on the following activities:

- promote detection at an early stage and appropriate treatment of women with breast and cervical cancer
- prevent heart disease and stroke
- promote detection and treatment of chronic conditions such as diabetes, renal disease, hemophilia and Alzheimer's disease
- provide assistance to victims of sexual assault
- educate health care providers regarding the identification and treatment of victims of violence

To promote healthy lifestyles by reducing behaviors that place people at greater risk of disease and disability, the Office of Community Health focuses on the following activities:

- reduce the use of tobacco products, alcohol and drugs
- prevent and control unintentional and intentional injuries including motor vehicle crashes, falls, fires and burns, drownings, homicides and suicides
- reduce the prevalence of physical inactivity

Fiscal Year 1993 Budget

The fiscal year 1993 General Revenue Fund (GRF) appropriation for the Office of Community Health was significantly affected by the deteriorating fiscal health of the state. An unusual midyear reduction made in January 1992 resulted in a 10 percent reduction in operations and a 3 percent reduction in grant appropriations. In fiscal year 1993, there were additional reductions of 25 percent for operations and 6 percent for grant appropriations.

The reduction in GRF appropriations for Personal Services and fringe benefits of more than $1 million resulted in a loss of 40 GRF positions. To further exacerbate the fiscal problem for fiscal year 1993, the operations support appropriations, including those for contractual services, travel, commodities, printing and telecommunications, were reduced by more than 50 percent.

On a more positive note, the Department received slight increases in federal funds for fiscal year 1993 for Supplemental Food Program for Women, Infants and Children (WIC); Title X-Family Planning and Preventive Health and Health Services Block Grant. The Department also received significant increases in federal funds for the Childhood Lead Poisoning Prevention and new Healthy Start programs.

For detailed budget information by division and fund source, please refer to the Appendix I and II.

Divisions

The Office of Community Health has reorganized and now contains five divisions: Dental Health, Family Health, Fiscal Operations, Health Assessment and Screening and Health Promotion. The mission of each division and its programs follows.

The ***Division of Dental Health***'s mission is to achieve optimal oral health for all residents of Illinois. Programs within the Division of Dental Health offer primary prevention activities designed to prevent and control oral disease using organized community efforts. The division conducts statewide preventive oral health programs focusing on baby bottle tooth decay, community water fluoridation, craniofacial anomalies, dental sealants, fluoride mouthrinse, orofacial injuries, smokeless tobacco and a variety of additional educational programs designed to meet the oral health needs of specific population groups in Illinois.

The ***Division of Family Health***'s mission is to prevent disease and improve the health of families in Illinois by advocating for and assuring the availability and accessibility of comprehensive health services. The division directly administers the federal Maternal and Child Health (MCH) Services Block Grant authorized by Title V of the Social Security Act. Programs within the Division of Family Health are Adolescent Health; Childhood Lead Poisoning Prevention; Family Counseling and Follow-up; Family Planning; Genetic Diseases; Healthy Moms, Healthy Kids; Healthy Start; Perinatal Care; Problem Pregnancy; Project SUCCESS and School Health. The division awards a grant to the Chicago Department of Health for comprehensive MCH services in the highest need areas in Chicago. The University of Illinois at Chicago, Division of Specialized Care for Children, is awarded 32.1 percent of the federal MCH Services Block Grant.

The ***Division of Fiscal Operations***' mission is to perform all fiscal activities for the Office of Community Health and provide contract and grant management assistance to programs.

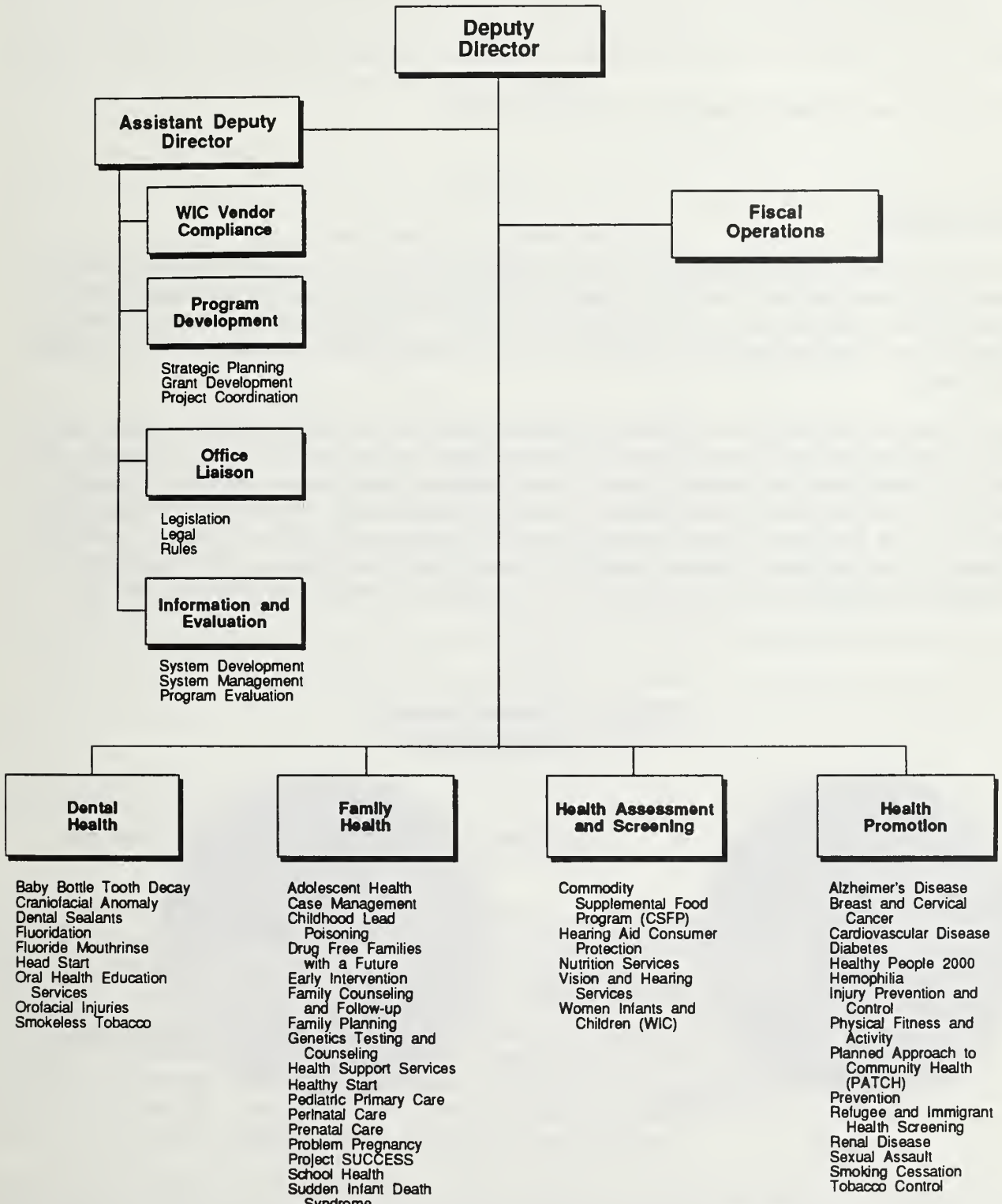
The ***Division of Health Assessment and Screening***'s mission is to promote the health of Illinois children, adolescents and the elderly through the integration of screening, assessment and preventive health programs into the existing network of service delivery. Programs within the Division of Health Assessment and Screening are Commodity Supplemental Food Program (CSFP); Hearing Aid Consumer Protection Program; Nutrition Services; Vision and Hearing Program and Women, Infants and Children (WIC) Supplemental Food Program.

The ***Division of Health Promotion***'s mission is to assure Illinois residents' access to services that foster healthy lifestyles and reduce risk factors for disease and injury. The programs within the Division of Health Promotion are Alzheimer's Disease, Breast and Cervical Cancer, Cardiovascular Disease Prevention, Chronic Renal Disease, Hemophilia, Intentional (violence) and Unintentional Injury Prevention and Control, Physical Fitness and Activity, Prevention Initiative, Refugee and Immigrant Health Screening, Sexual Assault Survivors Emergency Treatment Program and Tobacco Control.

The ***Office of Community Health Administration***'s mission is to provide technical assistance and support to Office of Community Health staff in the areas of data collection, analysis and coordination; grant writing; legislation; litigation; rules and program development.

Figure 2

Office of Community Health



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Program Title: **Maternal and Child Health**

Goal

To prevent disease and improve the health of families in Illinois.

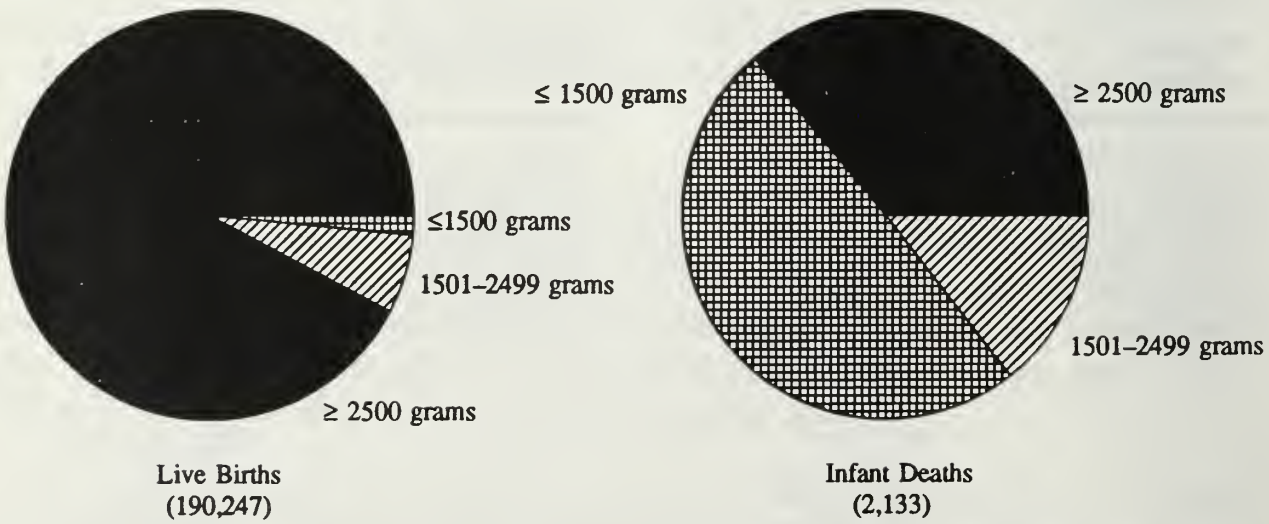
Needs Assessment

Illinois demonstrated substantial progress combating infant death in 1990. The state's infant mortality rate dropped to the lowest level ever. In 1990, the rate was 10.7 deaths per 1,000 live births compared with 11.7 reported in 1989. The previous lowest rate was 11.2 in 1988. However, the 1990 rate still compares unfavorably with the national rate (9.8 in 1989). In 1989 Illinois ranked 6th in the nation for the worst infant mortality rate.

A major cause of infant death is low birthweight (weighing less than 2,500 grams at birth). Illinois' rate of low birthweight has remained virtually constant for three decades; in 1960 and 1990 it was 7.6 percent, with virtually no change during the intervening years. Low birthweight infants account for about 7.5 percent of all live births each year; yet this small number of infants represents nearly 64 percent of all infant deaths (Figure 1). Low birthweight is the leading cause of U.S. infant death and contributes to health and developmental problems such as mental retardation, cerebral palsy, and blindness. Not surprisingly, low birthweight infants require more costly medical care than normal birthweight infants in their first year.

Figure 1

Live Births and Deaths by Birthweight
Illinois 1989 Birth Cohort

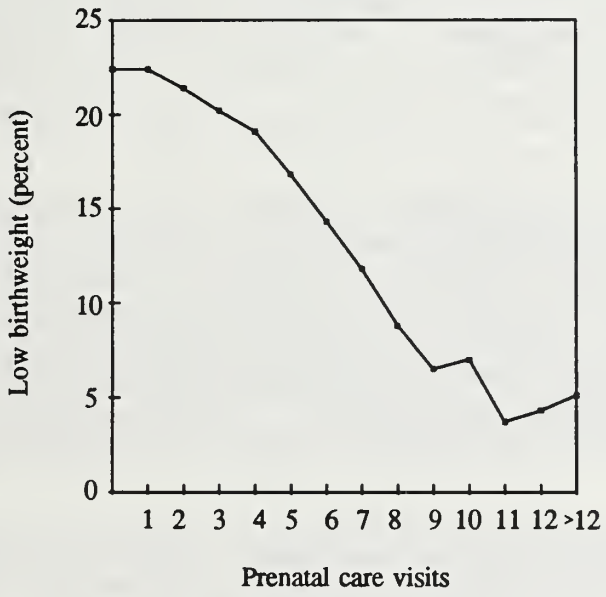


Source: IDPH, Division of Family Health

Two factors associated with the incidence of low birthweight are inadequate nutrition and inadequate or no prenatal care. The Institute of Medicine (1985) reviewed the literature on the relationship of prenatal care to low birthweight and concluded that "the overwhelming weight of evidence is that prenatal care reduces low birthweight. . . . A major theme of virtually all the studies reviewed is that prenatal care is most effective in reducing the chance of low birthweight among high-risk women, whether the risk derives from medical factors, sociodemographic factors or both."[1] Further, the same report found that every dollar spent on prenatal care results in a savings of $3.38 in neonatal intensive care costs.[2] The relationship between the amount of prenatal care women receive during pregnancy and the incidence of low birthweight is illustrated in Figure 2. Clearly, the provision of adequate, high-quality, risk-appropriate care is an essential part of the state's strategy to reduce low birthweight and infant mortality.

Figure 2

Low Birthweight by Prenatal Care Visits
Illinois 1990



Source: IDPH, Division of Family Health

Diet and adequate maternal weight gain are controllable factors that can contribute to more favorable pregnancy outcomes. WIC (the federal Special Supplemental Food Program for Women, Infants and Children) participants 30 through 34 years of age, who smoked and were underweight at the start of pregnancy had the highest prevalence of low birthweight infants (23.4 percent). The General Accounting Office (GAO) study, Early Intervention: Federal Investments Like WIC Can Produce Savings, finds that providing WIC benefits and services to low-income pregnant women markedly reduces the number of infants born with low birthweight. The study estimated that the federal government spent $296 million in 1990, but these benefits averted $853 million in health-related expenditures during the first year of life through the effects of WIC Program participation on the incidence of low birthweight.

The GAO study noted that WIC has other benefits besides reducing low birthweight, citing, for example, the program's positive effect on growth, reducing anemia, increasing immunization rates and improving cognitive ability and diet among infants and young children. Research has found that infants and children on WIC

have better outcomes for many of these measures than those from similar socioeconomic backgrounds who do not receive WIC services. Lower mortality rates have also been reported as a consequence of WIC participation.

All children need continuing access to comprehensive primary care. However, during state fiscal year 1991, only 30 percent of the 746,000 children in Illinois eligible for the Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program received primary pediatric care services. Recent estimates by the Department suggest that an additional 393,000 children in Illinois have no health insurance at all. Therefore, nearly one million children in Illinois receive less than adequate primary medical care.

Program Activities

General Overview

The Division of Family Health and the Division of Health Assessment and Screening, within the Office of Community Health, deliver maternal and child health services through grants awarded to local (county or municipal) governments and private, not-for-profit organizations. Five hundred grants are awarded by the Maternal and Child Health program to 170 agencies for direct services each year. Department staff conduct technical assistance, training and quality assurance activities to ensure the delivery of high quality services by these agencies. A summary of each of the grant programs composing the Maternal and Child Health program follows.

Adolescent Health—The Adolescent Health program is a statewide approach to the complex problem of children having children. The adolescent health component of the Maternal and Child Health program was reorganized for fiscal year 1993 and now comprises three grant programs: Comprehensive Projects, School Based Clinics and Adolescent Health Promotion Projects. These grant programs provide critical medical and social services to discourage teenage pregnancy, promote the physical and emotional health of pregnant teens and the infants and young children of teens, encourage pregnant teenagers and adolescent parents to remain in school, and improve teen parents' job opportunities. The adolescent health component helps adolescent parents surmount overwhelming odds and become effective parents and contributing members of society.

Childhood Lead Poisoning Prevention—The goal of the Childhood Lead Poisoning Prevention program is to reduce the prevalence of blood lead levels exceeding 10 µg/dl among children, ages 6 months through 5 years, to zero, as required by the Lead Poisoning Prevention Act. Several activities are underway to accomplish this objective, including measures to encourage physicians to screen and test for lead poisoning, outreach efforts, public awareness campaigns, a lead reporting system and database and the development of physician guidelines for the detection and management of lead poisoning.

CSFP—The Commodity Supplement Food Program (CSFP), also known as the Mother and Child Nutrition (MAC) program, is a federally funded program to help individuals who have a nutritional risk because of low income and poor conditions. Supplemental foods are provided to pregnant, breastfeeding and postpartum women; infants and children up to 6 years of age and the elderly. Only offered in Cook County, the program is administered by Catholic Charities. Non-perishable foods designed as nutrition supplements are distributed to participants out of CSFP warehouses. CSFP food packages include infant formula; adult and infant cereal and juice; nonfat dry and evaporated milk; farina; egg mix; dehydrated potatoes; rice; peanut butter and canned meats, fruits and vegetables. Eligible Cook County residents enroll in either WIC or CSFP—not both.

Family Counseling and Follow-up—This activity has two components: public health nursing services for high-risk pregnant women and infants, and grief counseling for families experiencing a death due to sudden infant death syndrome (SIDS). Follow-up services are also provided to families with a child found to have one of the genetic disorders for which the state screens.

Family Planning—The target population for the Family Planning program is Illinois residents of reproductive age whose income is below 250 percent of the poverty level. These services are comprehensive medical, educational, referral and social services related to the prevention, achievement, timing and spacing of pregnancy.

Genetic Diseases—The Genetic Diseases program screens newborns for biotinidase deficiency, congenital adrenal hyperplasia, galactosemia, hemoglobinopathies, hypothyroidism and phenylketonuria (PKU). In addition, the program coordinates a network of regional centers that offer individual or family counseling services and provide education on clinical genetics for health care professionals and consumers.

Healthy Moms, Healthy Kids—This 1993 gubernatorial initiative to improve child health and reduce infant mortality is a joint effort of the Illinois Department of Public Aid (IDPA) and the Department. The role of the Department is to support outreach efforts to inform families of available services, and to support case management of medically indigent families (those with incomes in excess of Medicaid eligibility but below 186 percent of the federal poverty level). Case management activities identify the services most appropriate to a family's needs, and then assist families in obtaining these services. The Department also provides some funds to pay for prenatal care, delivery and well child care services for medically indigent families. The role of IDPA is to support case management of families enrolled in Medicaid, and implement managed care for enrolled families in Chicago. The targeted populations for case management are children from birth to 3 years of age downstate, to 6 years of age in Chicago and pregnant women throughout the state.

This initiative consolidates the Department's Families with a Future, Prenatal Care and Pediatric Primary Care programs. Families with a Future supported community based networks of service providers to ensure the delivery of comprehensive services to pregnant women and infants in 27 areas of the state experiencing excessive levels of infant mortality. The Prenatal Care program provided case management and pregnancy-related education to low income women and also paid for prenatal, delivery and postpartum care for medically indigent women. All but four counties were served through the program. The Primary Pediatric Care program provided case management and payment for pediatric care for children and adolescents from uninsured or underinsured families. Eight local projects were supported through the program. Through Healthy Moms, Healthy Kids the Department will consolidate case management services; increase the number of recipients and provide limited support for primary care for infants, children, adolescents and pregnant women from medically indigent families throughout the state.

Healthy Start—Chicago was selected as one of 15 cities (from among more than 40 applicants) throughout the nation to participate in the president's infant mortality reduction initiative, Healthy Start. The Chicago Healthy Start Project's objective is to reduce the rate of infant mortality from 21.3 (1990) to 10.7 by September 30, 1996, within six contiguous communities: Near North, West Town, Near West, Near South, Douglas and Grand Boulevard. The Department is the only state health department in the nation to receive Healthy Start funding. The project was developed and will be overseen by a consortium of nearly 100 healthcare consumers, providers, government agencies and private businesses operating in the target area. Project operations began in fiscal year 1993.

The Chicago Area Healthy Start Consortium is committed to building on the state's and city's current infant mortality reduction efforts through four strategies: community economic development; expansion of case management, primary care, and support services; prevention, through peer and school-based education and outreach and follow-up, to insure that the most difficult-to-reach clients access services.

Nutrition Services—The Department's Nutrition Services program has three components. The first component involves the supplemental food programs including the Special Supplemental Food Program for Women, Infants and Children (WIC) and the Commodity Supplemental Food Program (CSFP). The nutrition program directs the health screening, food prescription and nutrition education components of the WIC Program. Activities are the development of risk criteria, educational tools and program monitoring and continuing education for local agency staff. Activities for CSFP are program monitoring and training for nutrition aids and local agency staff.

The second component of the nutrition program is the provision of nutrition information and education through other division programs and to personnel in other state and local agencies, organizations and institutions. This is provided through technical assistance and consultation, publications, presentations, conferences and exhibits. Examples of the education component include breastfeeding promotion, the Nutrition Poster Contest for all Illinois school-aged children and the National Nutrition Month promotion activities.

The third component of the nutrition program is nutrition assessment and surveillance. The program monitors and evaluates the nutritional status of at-risk, low income infants and children. In addition, the program monitors trends among at-risk, low income pregnant women, including the prevalence of prenatal risk factors and low birthweight. This information is shared through reports and used for program planning purposes.

Perinatal Care—Perinatal care consists of health and medical services provided to a pregnant woman, fetus and newborn just prior to birth, during labor and delivery and through the first month of life. There are 10 regional perinatal networks in Illinois, each having at least one Level III facility or Perinatal Center for the care of the most complex pregnancies and most critically ill newborns. The perinatal networks also provide education and consultation to health care professionals regarding management of high-risk pregnancies. Nationally, regional perinatal care centers have been credited with the reductions in infant mortality observed in the last 20 years.

Problem Pregnancy—The Problem Pregnancy program provides women who are encountering a variety of pregnancy-related problems with prenatal and postpartum care; nutrition and social services; employment and vocational counseling; and education on sexuality and parenting.

Project SUCCESS—Project SUCCESS, initiated by the lieutenant governor in fiscal year 1993, is an innovative, school-based program to help children deal with family and health problems that could impair their education. Six pilot sights have been selected: two communities in Chicago; a Chicago-area suburb; two medium-sized downstate communities and a rural community in Southern Illinois. Project SUCCESS underscores a commitment to education, early childhood intervention, positive parental involvement and better coordination of state and community services. Staff from the Maternal and Child Health program and Nutrition Services program have been assigned to each of the Project SUCCESS sites to provide consultation and technical assistance for the health and nutrition components of the initiative.

School Health—The goal of the School Health program is to provide all Illinois students with an optimal level of health conducive to learning through the development of comprehensive school health services. The program addresses the health needs of children throughout the state from birth to 21 years of age who are enrolled in preschool, elementary, middle and secondary school programs in addition to special education programs. Approximately 1.2 million students in 955 public school districts and 1,481 non-public schools are eligible for school health services. Additionally, the program serves school nurses, public health nurses, physicians, school counselors, social workers, therapists, psychologists, administrators and paraprofessionals who are involved with school health activities. School Health services include involvement in the planning, development, coordination and monitoring of school health activities through direct site visitation; state, regional and local meetings and annual statewide data collection.

Vision and Hearing Services—Staff of the Vision and Hearing Services program identify persons (3 through 20 years of age) with eye and ear disorders and diseases, through a systematic screening program with specific referral and follow-up procedures and resources. Screening activities are conducted by trained, certified nurses and technicians who receive periodic continuing education prior to recertification. Children with eye and ear disorders not able to receive appropriate medical follow-up through the private sector receive services through contractual eye and ear clinics coordinated by the Vision and Hearing Section staff.

Table 1

MATERNAL AND CHILD HEALTH

Target Populations, Recipients and Activity Measures

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
TARGET POPULATIONS[1]						
Pregnant women	195.5	186.8	187.3	187.8	188.2	191.1
Children 0–19 years	3,374.2	3,372.0	3,367.7	3,365.5	3,363.3	3,313.5
Women of reproductive age	2,682.3	2,683.0	2,659.0	2,635.0	2,612.0	2,594.0
RECIPIENTS[1]						
Pregnant women	77.0	121.8	122.3	123.5	149.6	172.2
Children 0–19 years	351.8	622.5	641.9	659.5	803.2	977.8
Women of reproductive age[2]	120.1	115.7	115.7	115.7	115.7	115.7
UNITS OF SERVICE[1]						
Medical Services	2,783.9	3,211.3	3,261.5	3,312.8	8,419.9	8,740.3
Education, counseling, follow-up, case management	869.4	1,377.6	1,399.1	1,460.4	4,741.3	5,787.5
Food packages	2,488.2	2,643.7	2,708.0	2,892.0	3,065.0	6,206.0
ACTIVITY MEASURES						
In-service training programs						
Nutrition/WIC	110	118	125	130	135	150
Vision/hearing	33	31	27	27	29	35
WIC vendors	125	150	150	150	150	150
Programs or projects funded/managed/monitored						
Adolescent Health	120	120	120	149	149	149
Childhood Lead Poisoning Prevention	NA	NA	3	7	7	7
Families with a Future	8	8	8	8	0[3]	0[3]
Family Counseling and Follow-up	76	70	69	65	65	65
Family Planning	57	57	57	57	57	57
Genetic Diseases	29	35	34	34	34	34
Healthy Moms, Healthy Kids	NA	NA	NA	NA	80	83
Healthy Start	NA	NA	NA	22	22	0[4]
Perinatal Care	10	10	10	10	10	10
Prenatal Care	69	71	72	78	0[3]	0[3]
Primary Pediatric Care	9	8	8	8	0[3]	0[3]
Problem Pregnancy	12	13	14	14	15	15
School Health	35	34	29	0[5]	0[5]	0[5]
WIC						
Vendors	2,100	1,900	1,700	1,600	1,500	1,500
Administering agencies	76	82	83	84	88	88

1. Count in thousands.
2. The number of women of reproductive age is not projected to increase due to the unlikelihood of increased federal funding for family planning services.
3. Part of Healthy Moms, Health Kids beginning fiscal year 1994.
4. Federal funding for Healthy Start is scheduled to end September 30, 1996.
5. Part of Adolescent Health beginning fiscal year 1994.

WIC—The Department administers the Special Supplemental Food Program for Women, Infants and Children (WIC) through 88 local agencies (approximately 200 clinic sites) throughout the state. The federally funded program provides nutrition education and counseling, supplemental foods and information about other health services. WIC benefits are provided to income-eligible pregnant, breastfeeding and postpartum women and infants and children up to 5 years of age who have medical and nutritional risks. Participants receive food packages based on their nutritional needs. WIC foods include milk, cheese, eggs, adult and infant cereal and juice, peanut butter, beans and infant formula. Food-specific coupons are printed on-site at WIC clinics statewide. Participants obtain their WIC foods by redeeming the food-specific coupons at WIC approved grocery stores (WIC vendors) throughout the state.

Program Data

The target populations for the maternal and child health programs are pregnant women, children and adults up to 20 years of age and women of reproductive age (aged 15 to 44 years). The number of pregnant women presented in Table 1 includes the number of live births after adjustments for fetal deaths and other terminations. The number of children and adults younger than age 20 years and the number of women of reproductive age are drawn from the 1990 census and projections based on that census.

The potential recipients of most maternal and child health program services are from families with incomes at or below 185 percent of the federal poverty standard. Payment for health services is closely coordinated with the Illinois Medicaid program and Medicaid program rates are used by the maternal and child health program when available. Present data collection systems do not provide unduplicated counts of persons receiving services. This problem will be addressed through the implementation of Project Cornerstone, the expansion of the WIC data system described below.

The increase between fiscal year 1990 and fiscal year 1991 in the number of pregnant women receiving services reflects the distribution of additional funds for outreach and case management obtained through using Department general revenue as matching funds for the Medicaid program. The projected increase between fiscal year 1993 and fiscal year 1994 in recipients and units of service anticipates full implementation of the Healthy Moms, Healthy Kids initiative.

The activity measures for the maternal and child health program are training and technical assistance provided to program grantees and the awarding of grants for each component of the program. Grant administration includes preparing contracts, monitoring expenditures, providing consultation and technical assistance to grantee agencies and reviewing quality of care provided. Beginning in fiscal year 1993, school health program grants were integrated with other adolescent health promotion projects.

The WIC Program completed conversion to the new WIC data system in April 1990. The Illinois WIC system greatly improves service delivery using personal computers to determine participant eligibility, certify and enroll participants (approximately 215,000) and issue food-specific coupons upon demand (more than 800,000 coupons per month). Project Cornerstone will expand this system to collect data for personal health services provided by all maternal and child health programs and provide an unduplicated count of persons served.

The WIC Vendor Management Act (effective August 3, 1989) and the WIC Vendor Management Code (effective December 1, 1990) gave the Department statutory authority to authorize, limit, educate and review compliance of WIC vendors; detail the qualifications and approval process for vendors and give the Department jurisdiction over fiscal management and accountability of the food delivery system. They further provide for the sanction of vendors who violate the rules.

The number of children screened for vision and hearing deficits continues to increase minimally each year. For the next several years, the Department expects to hold a constant number of annual vision and hearing screening training courses.

The number of other types of in-service training activities was reduced in fiscal years 1992 and 1993 due to staff reduction.

Table 2

MATERNAL AND CHILD HEALTH

Outcome Objectives and Actual Performance

	Actual 1990	Actual 1991	Actual 1992	Estimated 1993	Projected 1994	Projected 2000
Infant mortality rate[1]						
outcome objective	9.0	7.0	7.0	7.0	7.0	7.0
actual performance	10.7	NA	NA	NA	NA	NA
Low birthweight[2]						
outcome objective	5.0	5.0	5.0	5.0	5.0	5.0
actual performance	7.6	7.8	NA	NA	NA	NA
Pregnant women receiving care in first trimester[2]						
outcome objective	90.0	90.0	90.0	90.0	90.0	90.0
actual performance	77.2	76.8	NA	NA	NA	NA
Mortality among children age 1 through 19 years[3]						
outcome objective	NA	NA	NA	40.0	40.0	40.0
actual performance	44.9	49.1	NA	NA	NA	NA
Children receiving appropriate well child care[2]						
outcome objective	90.0	90.0	90.0	90.0	90.0	90.0
actual performance	30.0	30.0	NA	NA	NA	NA
Prevalence of obesity among WIC children[2]						
outcome objective	NA	NA	NA	11.0	10.5	9.0
actual performance	11.8	11.3	11.2	NA	NA	NA
Prevalence of anemia among WIC children[2]						
outcome objective	NA	NA	NA	22.0	21.5	21.0
actual performance	21.6	22.5	NA	NA	NA	NA
Prevalence of smoking among pregnant WIC clients[2]						
outcome objective	NA	NA	NA	25.0	24.5	24.0
actual performance	42.4	23.3	NA	NA	NA	NA
Prevalence of breastfeeding at hospital discharge among WIC clients[2]						
outcome objective	NA	NA	NA	30.0	35.0	40.0
actual performance	20.7	23.4	25.0	NA	NA	NA
Number of coordinated vision and hearing tests and follow-up services[4]						
outcome objective	2,500.0	2,500.0	2,500.0	2,565.9	2,623.5	2,991.6
actual performance	2,409.1	2,517.3	2,567.5	NA	NA	NA

1. Per 1,000 live births.
2. Percent.
3. Per 100,000 children.
4. Count in thousands.

Program Effectiveness

Illinois is making progress in reducing infant mortality. The 1990 rate of 10.7 deaths per 1,000 live births is the lowest ever, and 9 percent less than the previous year. Prior to 1990, the lowest rate achieved was 11.2 per 1,000 live births, in 1988.

The state's low birthweight rate is a persistent problem. No real improvement has been achieved since 1960. While minor fluctuations occur from year to year, the low birthweight rate in 1960 and 1990 were identical, at 7.6 percent of all live births.

Since 1987, there has been no improvement in the proportion of women receiving prenatal care early in pregnancy; the rate of women receiving care in the first trimester has remained at 77 percent.

The mortality rate for children in Illinois decreased 6 percent between 1989 and 1990. In 1989, the mortality rate was 47.7 per 100,000 children aged 1 through 19 years compared with 44.7 per 100,000 in 1990. Non-white teenagers aged 15 to 19 years reported the only increase, 124.2 to 145.7 from 1989 to 1990. Since 1985, the mortality rate for this group increased 63 percent (89.2 per 100,000 in 1985).

The proportion of children receiving well child care in accordance with the recommendations of the American Academy of Pediatrics is not known. However, the proportion of Medicaid eligible children participating in the Early Periodic Screening, Diagnosis and Treatment program of the Illinois Department of Public Aid is 30 percent statewide.

The prevalence of obesity among WIC children is gradually declining. During fiscal year 1990, the incidence of obesity was 11.8 percent for children; it was 11.2 percent for fiscal year 1992.

Anemia among WIC children increased. Data from fiscal year 1990 show an anemia prevalence of 21.6 percent, with an increase to 22.5 percent for fiscal year 1991. Data for fiscal year 1992 is not available.

Smoking during pregnancy among WIC clients has significantly decreased. Data from fiscal year 1990 show a smoking prevalence of 42.4 percent, with a decrease to 23.3 percent for fiscal year 1991. Data for fiscal year 1992 is not available.

Breastfeeding among WIC clients at hospital discharge is increasing. Data from fiscal year 1990 show a breastfeeding prevalence of 20.7 percent, with an increase to 25.0 percent for fiscal year 1992.

Prevention is the most efficient means to protect against eye and ear disorders and diseases. The number of vision and hearing screening tests delivered to Illinois children has increased slightly each year. This trend is expected to continue throughout the decade.

Assurances

Interagency Cooperation

The Maternal and Child Health program works closely with the University of Illinois at Chicago, Division of Specialized Care for Children, which receives 32.1 percent of the Maternal and Child Health Services Block Grant. The Department is a member of the Interagency Coordinating Council on Early Intervention, which is charged with implementing Individuals with Disabilities Education Act in Illinois. The Maternal and Child Health program also works with the Illinois Department of Public Aid to implement the Healthy Moms, Healthy Kids initiative. The departments of Children and Family Services, Alcoholism and Substance Abuse and Public Aid also work with the Department on the implementation of the president's Healthy Start initiative in the city of Chicago. These coordinated efforts have been increased to better utilize state dollars and implement new federal mandates.

Outside of the state network, the Department has successfully developed relationships with the Illinois Planning Council on Developmental Disabilities and the Ounce of Prevention Fund. Ongoing liaison is established with the Maternal and Child Health Coalition, the Illinois Association of School Nurses, Illinois School Health Association, Illinois Nurses' Association, Illinois Public Health Association, Illinois Primary Health Care Association, Illinois Chapter of the American Academy of Pediatrics, the Illinois Section of the American College of Obstetrics and Gynecology and the Illinois Academy of Family Physicians.

The Department also continues to work with the regional school audiology programs, regional special education cooperatives and local health departments to provide vision and hearing diagnostic services for selected children. Children eligible for these clinical services are those who cannot obtain such services because of financial limitations, who live in areas remote from such services and who are refused such services because of their mental or developmental limitations. The cooperative program with the Illinois Society for the Prevention of Blindness is also ongoing; the society provides eyeglasses to children who cannot afford them.

In addition, the Department cooperates with Illinois Dietetic Association, Illinois Nutrition Association, Illinois Community Action Association, University of Illinois Cooperative Extension, Expanded Food and Nutrition Education Program, LaLeche League, Regional Breastfeeding Task Forces, dietitians from hospitals and community clinics and programs training dietitians and nutritionists.

Family Impact
The Maternal and Child Health program strengthens Illinois' families by offering medical, nutritional and supportive services to women and children, especially those who are poor or nearly poor.

Recommended Changes to Program

In 1990, the Department implemented a distributed system that automated information and tracking operations of one key program area, WIC. Then the Department began Project Cornerstone, a new foundation for the delivery and management of maternal and child health services in Illinois. Project Cornerstone is a personal computer-based system that uses the technology and design considerations of the WIC system to merge data from and share client information with other maternal and child health programs. This capability was demonstrated with the merging of immunization data with WIC system data. The Department will continue to expand the Project Cornerstone database with the addition of client-tracking program information of Adolescent Health; Family Planning; Healthy Moms, Healthy Kids; High Risk Maternal and Infant Follow-up; Lead Poisoning Prevention; Prenatal Care and Vision and Hearing Screening.

Project Cornerstone includes many electronic features that improve program operations: a single database for multiple program reporting and client notification; a unique statewide participant identification number; a single application to determine eligibility for all maternal and child health programs; the ability for case managers to create individualized care plans, refer participants to service providers and track service delivery; and multiple provider access to client health status and service delivery information. The status of an individual participant's enrollment in any maternal and child health program can be determined immediately, onsite, without the delay associated with manual recordkeeping. Multiple program service sites can access the same participant information. Project Cornerstone's database expansion will be a major undertaking of the Department for the next four years.

During fiscal year 1993, the Department selected Catholic Charities to establish WIC Food Centers in the Chicago area by May 1, 1993. This new initiative will improve services to women and their children as part of the infant mortality initiative, provide job training and placement for individuals within their communities and reduce fraud. This three-year project involves the direct distribution of WIC foods at six Chicago-area WIC clinics that have more than 13,000 participants. The centers' operating expenses will be derived from the difference between the wholesale purchase price and the approved retail reimbursement rate. The Department is considering additional sites in the Chicago area. Meanwhile, Catholic Charities has established a participant advisory committee to solicit and review participant concerns.

Legal Citations

AIDS Confidentiality Act, 410 ILCS 305/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 7301 *et seq.*)

Child Nutrition Act of 1966, 42 USC 1771

Child Vision and Hearing Test Act, 410 ILCS 205/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 23, ¶ 2331 *et seq.*)

Communicable Disease Prevention Act, 410 ILCS 315/0.01 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 22.10 *et seq.*)

Counties Code, 55 ILCS 5/1-1001 *et seq.* (Ill. Rev. Stat. 1991, ch. 34, ¶ 1-1001 *et seq.*)

Developmental Disability Prevention Act, 410 ILCS 250/0.01 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 2100 *et seq.*)

Early Intervention Services System Act, 325 ILCS 20/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 23, ¶ 4151 *et seq.*)

Family Planning Services and Population Research Act of 1970, 42 USC 300 (a)(6)(a)

Hearing Aid Consumer Protection Act, 225 ILCS 50/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111, ¶ 7401 *et seq.*)

Hospital Licensing Act, 210 ILCS 85/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 142 *et seq.*)

Individuals with Disabilities Education Act, 20 USC 1400

Infant Mortality Reduction Act, 410 ILCS 220/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 7001 *et seq.*)

Lead Poisoning Prevention Act, 410 ILCS 45/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 1301 *et seq.*)

Phenylketonuria Testing Act, 410 ILCS 240/0.01 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 4902.9 *et seq.*)

Prenatal and Newborn Care Act, 410 ILCS 225/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 7021 *et seq.*)

Problem Pregnancy Health Services and Care Act, 410 ILCS 230/1-100 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 4601-100 *et seq.*)

School Code, Health examinations and immunizations, 105 ILCS 5/27-8.1 (Ill. Rev. Stat. 1991, ch. 122, ¶ 27-8.1)

School Code, Critical Health Problems and Comprehensive Health Education Act, 105 ILCS 110/3 (Ill. Rev. Stat. 1991, ch. 122, ¶ 863)

Social Security Act, Title V, 42 USC 701 *et seq.*

Social Services Block Grant, 42 USC 1397 *et seq.*

WIC Vendor Management Act, 410 ILCS 255/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 7551 *et seq.*)

WIC Vendor Management Code, 77 Ill. Adm. Code 672

References

1. Institute of Medicine. (1985). *Preventing low birthweight: Summary.* Washington, D.C.: National Academy Press. pp. 18–19.

2. Institute of Medicine. (1985). *Preventing low birthweight.* Washington, D.C.: National Academy Press. pp. 212–237.

Program Title: **Health Promotion**

Goal

To assure Illinois residents' access to services that foster healthy lifestyles and promote reduction in personal and environmental risk factors for disease and injury.

Needs Assessment

Most of the leading causes of death are associated with certain behaviors and lifestyle choices. Many diseases and conditions have behavior risk factors in common. For example, smoking is a risk for both heart attack and lung cancer. Alcohol abuse is a risk factor for injuries, cirrhosis of the liver and some cancers. Health Promotion staff conduct programs to reduce the prevalence of behavioral risk factors, thereby reducing morbidity and mortality from diseases and conditions that result from those behaviors. A description of the areas targeted by the division follow.

Alcohol Use—Alcohol consumption is a major risk factor for motor vehicle crashes, especially among the 18-to-24-year-old age group. An estimated 32 percent of alcohol-related deaths involve motor vehicles. Fifty-one percent of all motor vehicle crashes (MVCs) are associated with alcohol. In Illinois, 6.3 percent of adults surveyed say they drink and drive. Among adults aged 25 to 34 years, 9.8 percent say they drink and drive, and of those aged 18 to 24 years, 12.3 percent drink and drive. An analysis of data from the Behavior Risk Factor Surveillance System (BRFSS) shows that in any given month more than 350,000 Illinois drivers drive when they have had too much to drink.

Injuries—Injuries rank fourth in the leading causes of death in Illinois and first among the leading causes of years of life lost. Motor vehicle injuries account for more than half the deaths from injury. Falls, fires and poisonings rank in that order as contributors to injury deaths.

In 1991, there were 1,289 motor vehicle-related deaths in Illinois. Motorcycle crashes accounted for 1.1 percent of all motor vehicle crashes but 8.4 percent of all fatal motor vehicle crashes (Illinois Department of Transportation, 1991). Almost 90 percent of these deaths involved persons aged 44 years or younger and more than 80 percent involved persons aged 20 to 44 years. In crashes involving motorcyclists and their passengers, helmet use reduces the incidence of severe injuries. Studies indicate that in states with laws mandating helmet use, the use of helmets increases and deaths are reduced by 24 to 30 percent.

Physical Fitness and Activity—Among adult populations, increased physical activity has been associated with a reduced incidence of coronary artery disease, hypertension, non-insulin dependent diabetes mellitus, depression, colon and reproductive cancers, osteoporotic fractures and total mortality.

Despite this medical evidence, only 23 percent of the population in Illinois engages in routine and adequate physical activity. Nationally, the combination of physical inactivity and deficient diets together with tobacco use ranks ahead of infectious diseases as the leading preventable contributing factors to premature death of Americans. Department data from 1991 suggests that between 60 percent and 70 percent of Illinois residents are at risk for cardiovascular disease because of sedentary lifestyles. Between 25 percent and 35 percent of Illinois residents report no leisure-time physical activity. The estimated national cost of coronary heart disease alone is between $41.5 and $56 billion—a significant portion of which is paid for through Medicaid programs.

Most distressing is the fact that many preventable diseases in adults stem from lifestyle choices made in childhood. Recent studies suggest that physical activity in childhood is a determinant of physical activity in adulthood. The Centers for Disease Control and Prevention's (CDC) 1990 Youth Risk Behavior Survey indicates that the prevalence of vigorous physical activity declines with increasing grade levels from 40.1 percent in 9th grade to 31.8 percent in 12th. Moreover, Illinois research trends indicate that among youth, obesity conditions are on the rise while cardiovascular fitness levels are on the decline. As many as 60 percent of children in the United States exhibit at least one modifiable adult risk factor for coronary artery disease by the age of 12 years.

Current research shows an inverse relationship between physical fitness and substance abuse among at-risk youth populations. Better fitness may also deter violent behavior associated with substance abuse among adolescents.

Tobacco Use—The Surgeon General's report estimated that in 1985, one in six deaths in this country was caused by cigarette smoking. Further, estimates indicate another 43,000 deaths among nonsmokers can be attributed to pollution from secondhand smoke. A 1985 study showed that approximately 16,000 Illinoisans' deaths were attributed to cigarette smoking while an additional estimated 250 deaths were caused by health hazards associated with secondhand smoke.

In 1991, the percentage of women smokers exceeded that of men for the first time (approximately 24.1 percent of females smoke vs. 23.0 percent of males). The fastest growing segment of smokers is women younger than 23 years of age. This fact is particularly alarming when considering the effects of smoking during pregnancy and the presence of secondhand smoke in the environment of young children. It is a well established fact that cigarette smoking during pregnancy is a major risk factor for infant mortality. Pregnant women who smoke are more likely than nonsmokers to deliver babies who are premature, are low birthweight, have respiratory problems and die within the first year of life. In addition, children living in households with smokers have more allergies, hospitalizations and respiratory infections than those who live in smoke-free environments. In 1988, 29.8 percent of Illinois women receiving Women, Infant and Children (WIC) services were smokers at the time of delivery.

A major contribution to tobacco use among children and adolescents is their relatively easy access to purchase of tobacco products, both nationally and in Illinois. In marked contrast to the trends in virtually all other areas of smoking control policy, the number of legal restrictions on children's access to tobacco products has decreased over the past quarter century. Illinois has laws that prohibit sales of tobacco products to persons younger than aged 18 years. Yet, studies indicate that vendors' compliance with minimum-age-of-purchase laws is the exception rather than the rule. Most smokers start before 18 years of age. Since smoking prevalence data are not available for people less than 18 years of age, the group aged 18 to 24 years is used as a surrogate. Data obtained from the Illinois BRFSS indicate that in 1991, 19.1 percent of the population aged 18 to 24 years were smokers.

Program Activities

General Overview

The Health Promotion program is administered by the Division of Health Promotion within the Office of Community Health. A summary of specific programs composing the Health Promotion program follows.

Illinois Clean Indoor Air Act—The primary purpose of the Illinois Clean Indoor Air Act, effective July 1, 1990, is to protect Illinois citizens from the health hazards of second hand smoke. The Department provides information and assistance to encourage compliance with the law. As of June 30, 1992, the Department has responded to a total of 944 such inquiries (470 in fiscal year 1991 and 474 in fiscal year 1992) and has distributed more than 600 packets of information concerning the law.

Injury Prevention and Control—The division continues to build statewide multidisciplinary coalitions that develop and implement injury interventions. In fiscal year 1993, the division focused on securing funds for programs tailored to specific priority groups that used interventions identified in the Illinois Strategic Plan for Injury Prevention and Control. The division promotes and supports training for public health, medical and social service professionals on the identification, care and referral of victims of violence.

To reduce the risk of injuries from drinking and driving, the division provides training, technical assistance and funds to demonstration programs in four communities: Champaign, Jackson, McLean and St. Clair counties. These communities are required to form coalitions of local governments, private organizations and individuals to conduct activities in schools, worksites, health care facilities and other community settings. Examples of activities are: passage of local ordinances to restrict entrance to bars to people aged 21 years and older, provision of school health education on alcohol-related topics and special training for people who serve alcohol in bars and restaurants.

In fiscal year 1993, the division also funded 10 local health departments (LHDs) under the Prevention Initiative to conduct programs that reduce intentional and unintentional injuries.

Operation FirstChoice—The governor's Physical Fitness and Sports Council initiated Operation FirstChoice as a programming effort within the Illinois Army National Guard's Demand Reduction Section. FirstChoice is a community-based fitness program that promotes health and life skill development of at-risk youth ages 8 to 18 years of age and counteracts substance abuse, dropout rates and gang influences. Selected National Guard personnel and community leaders receive comprehensive training of all components of FirstChoice. These Guard personnel train community leaders and both groups then work with the target population. The first two inner-city communities selected for this program are Greater Grand Boulevard and Humboldt Park. Program expansion will include: more inner-city sites; development of downstate and rural sites; more follow-up and ongoing training; program applications for adult populations 18 years to 40 years of age and criminal offenders and a component to address violent behavior through alternative dispute resolution skills.

Physical Fitness Summit—Division staff will convene an assembly of state and national leaders in the fields of physical activity, health, fitness and behavior. This assembly will make recommendations to motivate physical fitness among all Illinois residents. This summit is targeted for late spring of 1994.

Prenatal Smoking Cessation—As part of the CDC-funded Prenatal Smoking Cessation (PSC) project designed to prevent morbidity and mortality associated with maternal smoking, the Department trains LHD staff to provide smoking cessation counseling to clients, provides smoking cessation materials to support the counseling and collects data on the outcome of the counseling.

The University of Illinois Survey Research Laboratory staff will provide a comprehensive evaluation of the program in fiscal year 1994, using several data collection instruments, including client and provider opinion surveys.

Table 1

HEALTH PROMOTION

Target Populations and Activity Measures

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
TARGET POPULATIONS						
University population (Champaign, Jackson, McLean, St. Clair Counties)	472,000	472,000	472,000	472,000	472,000	0[1]
WIC/Prenatal clients who smoke	7,600	7,546	7,495	7,434	7,385	7,009
Illinois students eligible for participation in the Smoke Free Class of 2000	134,540	134,185	133,967	135,780	138,051	138,051
ACTIVITY MEASURES						
Injury control						
educational materials distributed	NA	NA	10,000	10,000	10,000	10,000
consultations provided	NA	NA	41	72	72	72
Tobacco use reduction by WIC and prenatal clinics' clients						
educational materials distributed	1,500	1,500	2,500	7,500	10,000	12,500
workshops presented	12	11	12	12	12	12
Tobacco use reduction among persons less than 18 years of age						
educational materials distributed	1,821,407	1,848,166	1,814,798	1,840,292	1,866,940	1,952,697
persons participating in educational programs	47,069	37,059	37,000	27,339	27,000	27,000

1. Grant ends September 30, 1994.

During the two years of the project, which began September 1991, LHDs offered smoking cessation counseling to pregnant women. Division staff monitored the PSC activity through site visits and telephone calls.

Prevention Initiative—The division provides money from the Preventive Health and Health Services Block Grant to fund risk reduction projects in LHDs. During fiscal year 1993, funded projects developed coalitions, collected data and planned interventions which began in March 1993. LHDs choose from the following risk reduction interventions: alcohol and drug use, breast cancer, cervical cancer, nutrition, physical activity and fitness, tobacco use, unintentional injuries and violent and abusive behavior. During the year, division staff will provide technical assistance to funded projects.

Smoke Free Class of 2000—The Department is an endorsing agency and active supporter of the Illinois Smoke Free Class of 2000 (SFC2000). Illinois' SFC2000 project, part of a national project sponsored by the American Heart Association, the American Lung Association and the American Cancer Society, recruits symbolic classes to represent the students who will graduate high school in the year 2000. During the 12-year period the students in the participating classes (fifth grade in 1992 to 1993) will receive age-appropriate educational materials concerning the advantages of not smoking and publicity as ambassadors of a new smoke-free generation. Illinois' SFC2000 is a statewide project serving approximately 50,000 students in more than 900 schools.

Table 2

HEALTH PROMOTION

Outcome Objectives and Actual Performance

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
Alcohol motor vehicle crash deaths[1]						
outcome objective	3.9	4.0	3.9	3.7	3.5	2.5
actual performance						
Champaign County	6.9	3.5	3.5	NA	NA	NA
Jackson County	4.9	8.2	6.6	NA	NA	NA
McLean County	6.2	9.3	5.4	NA	NA	NA
St. Clair County	8.4	10.3	5.7	NA	NA	NA
Smoking prevalence[2] by WIC clients receiving services through local health departments						
outcome objective	29.5	27.5	26.5	24.5	22.5	20.0
actual performance	31.4	29.9	28.3	NA	NA	NA
Prevalence of smoking among persons less than 18 years of age[2]						
outcome objective	23.0	23.0	22.0	21.0	20.0	15.0
actual performance	25.0	25.0	NA	NA	NA	NA

1. Per 100,000.
2. Percent.

Assurances

Interagency Cooperation

Interagency planning and implementation are integral to the division's programs. Each program works with relevant state agencies, educational institutions and voluntary groups. These include:

American College of Emergency Physicians
American Medical Association
Governor's Physical Fitness and Sports Council
Illinois Courts: Administrative Office
Illinois Academy of Family Physicians
Illinois Alcohol and Drug Dependency Association
Illinois Army National Guard
Illinois Association of Maternal and Child Health
Illinois Association of Public Health Administrators
Illinois Attorney General
Illinois Coalition Against Domestic Violence
Illinois Coalition Against Sexual Assault
Illinois Coalition Against Tobacco
Illinois College of Emergency Physicians
Illinois Commission on the Accreditation of Health Care Organizations
Illinois Department on Aging
Illinois Department of Alcohol and Substance Abuse
Illinois Department of Children and Family Services
Illinois Department of Public Aid
Illinois Department of Transportation
Illinois Heart Association
Illinois Hispanic Human Services Association
Illinois Hospital Association
Illinois Information Service
Illinois Lung Association
Illinois Public Health Association
Illinois Secretary of State
Illinois Society of Public Health Education
Illinois State Council, Emergency Nurses Association
Illinois State Board of Education
Illinois State Police
Joint Commission on the Accreditation of Healthcare Organizations
Midwest Nursing Research Society
Mothers Against Gangs
National Commission on Correctional Health Care
National Committee for Prevention of Child Abuse
National Women Abuse Prevention Project
Office of the Governor
Office of the Lieutenant Governor
Prevention Resource Center
Smoke Free Class of 2000 Coalition
Travelers and Immigrants Aid
United Charities
University of Illinois: Prevention Research Center, School of Nursing, School of Public Health and Survey Research Laboratory

Family Impact

The services of the division are designed to prevent or reduce specific risk factors which adversely affect the health of Illinois' residents, thus helping Illinois families to reduce or avoid the costs, loss of productivity, hospitalizations and stress associated with diseases and injuries.

Recommended Changes to Program

In fiscal year 1994, the Divisions of Health Promotion and Adult and Senior Health have been merged into one division, the Division of Health Promotion.

Legal Citations

Civil Administrative Code of Illinois, 20 ILCS 2310/55.02, 55.17 (Ill. Rev. Stat. 1991, ch. 127, ¶ 55.02, 55.17)

Illinois Clean Indoor Air Act, 410 ILCS 80/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 8201 *et seq.*)

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Program Title: **Adult and Senior Health**

Goal

To minimize the incidence and impact of morbidity and mortality due to chronic diseases and conditions, thus increasing longevity and improving the quality of life for Illinois residents.

Needs Assessment

As the population of the United States grows older, the problems posed by chronic diseases and conditions increasingly demand our attention. Chronic diseases have a profound effect not only on mortality but also on quality of life. The Department administers programs addressing: Alzheimer's disease, breast and cervical cancer, cardiovascular disease, diabetes, hearing disorders, hemophilia, and renal disease.

Alzheimer's Disease—Approximately 300,000 Illinois citizens are victims of Alzheimer's disease and related disorders. It is estimated that 23 percent of those older than 65 years of age may be afflicted with Alzheimer's disease. In Illinois, the disease and its complications may contribute to over 14,900 deaths in 1992.

The cause of Alzheimer's disease and preventive measures are unknown. Victims may live 10 to 20 years after symptoms appear and may remain physically strong even though totally incapable of self-care. Alzheimer's victims require 24-hour care because symptoms may occur at any hour. This is true in mildly afflicted patients whose families can care for them at home as well as for severely afflicted patients in skilled nursing facilities. The custodial nature of the care required by Alzheimer's patients places a tremendous burden on family members. Alzheimer's disease often has two victims—the patient and the family.

Cancer—Breast and cervical cancer are significant threats to the health of women in Illinois. Each year, these two cancers together account for almost 40 percent of all cancers in women. In 1990, the total number of deaths due to breast and cervical cancer was 2,166 and 207, respectively. The five-year average annual age-adjusted Illinois breast cancer incidence rate for 1986–1990 was 107.6 per 100,000 women. Among white women the rate was 116.9 per 100,000 and among non-white women 79.1 per 100,000. During this same period, the overall average annual age-adjusted cervical cancer incidence rate was 39.3 per 100,000 women. As with breast cancer, white women had a higher incidence rate (43.8 per 100,000) than non-white women (36.8 per 100,000).

A baseline study conducted in selected Chicago community areas revealed excessive breast and cervical cancer mortality rates. Higher risk was observed for women of low socioeconomic background, members of minority groups and women with a low level of education. The high mortality rate observed for minorities, in the absence of a correspondingly high incidence rate, supports the notion that there is inadequate detection and treatment of early stage cervical cancer among minority women in Chicago.

Breast cancer rates increase as age increases for both blacks and whites in Illinois. Although the lowest age-specific rate is found among women from all other remaining races combined, the interpretation of data for this group should be guarded, since the small number of women in this third group could affect the stability and validity of these numbers.

Women with breast cancers that are diagnosed in early stages, when treatment is most effective, have the highest survival rates. Between 1986 and 1989, only 61 percent of all breast cancer cases among Illinois women were diagnosed in an early stage, and among the three race groups, white women were more often diagnosed in an early stage than black women. In 1990, 65 percent of all breast cancer cases were detected

at an early stage, an increase from the 59.9 percent early detection rate of 1986. Although the trend is toward an increasing proportion of breast cancers diagnosed early, Illinois is still far from the *Healthy People 2000* objective of detecting 80 percent of all breast cancer cases at an early stage.

Cancer of the cervix is the third most common cancer in Illinois women. Women with cervical cancers diagnosed and treated at the non-invasive stage (localized only to the cervix with no involvement with adjacent organs or nodes) have the best survival rates. From 1986 to 1989, 73.5 percent of all cervical cancers among Illinois women were diagnosed at a non-invasive stage.

Rates for invasive cervical cancer (spread to the uterus, local nodes and adjacent organs) are vastly different from non-invasive cancers. Between 1986 and 1989, the proportion of invasive cases increased with age for all races. However among black women, the rates for invasive disease are highest compared to other races in every age group and the rates increase with age.

Cardiovascular Disease—Despite dramatic declines in mortality from heart disease and stroke in the past two decades, about 7 million Americans are affected by coronary artery disease. Cardiovascular diseases still cause more deaths in the United States than all other diseases combined. Heart disease and stroke accounted for over 40,000 deaths (41 percent of all deaths) in Illinois in 1990. Reductions in major risk factors—high blood pressure, high blood cholesterol and smoking—significantly impact cardiovascular mortality.

Diabetes—More than 660,000 Illinois residents have diabetes. Complications of diabetes include adverse pregnancy outcomes and wide ranging effects on the circulatory system, increasing the risk of foot problems, vision problems (possibly blindness), cardiovascular disease and kidney disease. In Illinois, the annual number of deaths for which diabetes was listed as a "cause" (i.e., contributing factor) reached 8,297 in 1988 from 7,612 in 1980 (Table 1). Although in 1989, the number of deaths due to diabetes as a contributing factor declined to 7,679. The number of deaths for which diabetes was an underlying cause (i.e. giving rise to a chain of events that lead to death) steadily increased from 1,825 in 1988 to 2,247 in 1990 (Table 2).

Currently, nearly 137,000 Illinoisans suffer from eye complications due to diabetes. The number of persons with complications continues; 680 newly diagnosed cases of blindness occur each year. But proper eye examinations and early intervention can reduce the risk of diabetes-related blindness by 60 percent.

Diabetic nephropathy (kidney disease) can lead to end-stage renal disease, a serious condition in which a patient's survival depends on either dialysis or kidney transplantation. The number of new cases of end-stage renal disease due to diabetes in Illinois increased fourfold during the 1980s from 136 in 1980 to 548 in 1989. The number of persons undergoing treatments for end-stage renal disease due to diabetes has also increased almost sixfold during the 1980s, from 327 in 1980 to 1,953 in 1989.

Table 1

Diabetes as a Cause of Death

Illinois: 1980–1989

Year	Number	Rate[1]
1980	7,612	66.6
1982	7,750	67.5
1984	7,699	66.8
1986	8,089	70.0
1988	8,297	71.5
1989	7,679	65.9

1. Per 100,000.

Source: Diabetes Surveillance, CDC 1991; IDPH, Vital Statistics

Table 2

Diabetes as an Underlying Cause of Death

Illinois: 1988–1990

Year	Number	Rate[1]
1988	1,825	17.4
1989	2,108	18.1
1990	2,247	19.6

1. Per 100,000.

Source: IDPH, Vital Statistics

Hearing—Nationally, one out of 10 persons has some degree of hearing loss, and as many as 60 percent of Americans 65 years of age and older may be affected by hearing impairment. Thus, approximately 855,623 Illinois seniors possess varying degrees of hearing impairment, causing a deterioration in their quality of life. Hearing aids provide assistance to many hearing impaired persons. In 1991, Illinois residents purchased 65,548 hearing aids. The Hearing Aid Consumer Protection Act, administered by the Department, provides for the licensure by examination of potential hearing aid dispensers, the education of potential hearing aid consumers, the continuing education of licensed hearing aid dispensers and investigations and resolutions of consumer complaints. To date, there are 854 licensed hearing aid dispensers in Illinois.

Hemophilia—There are approximately 900 identified hemophiliacs in Illinois; 805 are registered in the Department's Hemophilia Program. Hemophilia is a coagulation deficiency disease inherited almost exclusively by male children and transmitted through females. Severe hemophiliacs must receive antihemophilic factor to prevent crippling or death. In fiscal year 1992, 71 patients received financial assistance for treatment. Approximately 80 patients will qualify for and receive financial assistance from the Hemophilia Program in fiscal year 1993 and 85 in fiscal year 1994.

Nutrition—Dietary factors are associated with five of the 10 leading causes of death in the United States: coronary heart disease, some types of cancer, stroke, noninsulin-dependent diabetes mellitus and atherosclerosis. Obesity is associated with the risk factors for many chronic diseases including heart disease, diabetes mellitus, high blood pressure, stroke, some types of cancer and gallbladder disease. Obesity affects about 26 percent of the general population. According to the 1990 Behavior Risk Factor Surveillance Survey (BRFSS), which used data collected from 1986 through 1988, the Illinois population at risk due to obesity was 25.4 percent, 26.2 percent of males and 24.9 percent of females. This is an increase from the previous survey results (1984–1986) of 22.8 percent.

As the U.S. population ages, the number of senior citizens at risk for inadequate nutrition increases. Unfortunately, few programs target this vulnerable group. In 1990 the Commodity Supplemental Food Program (CSFP) broadened the population it serves to include low income seniors aged 60 years or older living in specified sites in the Chicago area. This program currently serves 7,000 senior citizens by providing non-perishable foods as nutrition supplements (food packages include juice, evaporated or powdered milk, dry cereal or farina, rice, macaroni or instant potatoes, canned vegetables or fruit, powdered egg mix, canned meat, cornmeal, peanut butter or dried beans, honey and prunes). In addition, participants receive nutrition education, including ways to use the foods provided.

Renal Disease—As of August 1, 1992, there were approximately 8,300 end-stage renal disease patients in Illinois. End-stage renal disease has numerous etiologies, including hypertension, diabetes, polycystic kidney disease and nephritis. To survive, patients with end-stage renal disease must receive an organ transplant or regular renal dialysis treatments. There were 1,115 patients who received financial assistance for treatment in fiscal year 1992 and 1,155 in fiscal year 1993. A projected 1,215 patients will receive financial assistance in fiscal year 1994.

Program Activities

General Overview

The Adult and Senior Health program is managed by the Division of Health Promotion within the Office of Community Health. Specific programs related to chronic diseases provide two services—payment and disease control. Alzheimer's Disease, Cancer, Cardiovascular Disease Prevention, Diabetes, and Hearing Aid Programs are the disease control program's focus. Chronic Renal Disease and Hemophilia programs constitute the payment programs. Each of these programs strives for common outcomes: disease prevention, reduction of disease complications, improvement in the quality of life, control of the disease process, and reduced loss of life. Program efforts are interrelated because the diseases themselves are interrelated. A description of the chronic disease programs follows.

Alzheimer's Disease—The Alzheimer's Disease Program awards grants to establish Alzheimer's Disease Assistance (ADA) Centers at post-secondary higher educational institutions that have a medical school affiliation and a medical center. Each designated ADA Center is responsible for establishing a comprehensive system of regional and community based services for the identification, evaluation, referral and treatment of victims.

The program also awards Alzheimer's research grants funded from a voluntary state income tax contribution. The overall goal of the research is to help find a cure for the disease. The program recruits and administers an Alzheimer's Disease Advisory Board to assist in program direction.

Cancer—The Department, in collaboration with the Centers for Disease Control and Prevention (CDC), Illinois Cancer Council (ICC), Chicago Department of Health (CDOH), and University of Illinois Survey Research Laboratory conducted a six-year Cervical Cancer Control and Demonstration Project in Chicago which began in the fall of 1986 and ended in September 1992. The purpose of the study was to describe cervical cancer morbidity and mortality for the city of Chicago. The study focused on providers, efficacy of slides and laboratory testing procedures and patient knowledge and follow-up. The intervention phase included the development of a program to evaluate provider services and identify deficiencies and initiate corrective action through education. The program also educated the patient on the need for prevention and follow-up and established a follow-up system for the Chicago Department of Health Neighborhood Health Centers. A report documenting the results of the studies and interventions is available.

In October 1992, the Department began to develop the Illinois Breast and Cervical Cancer Control Plan (the Plan). The six essential elements of the Plan and the purpose of each follows:

1) A **State Coalition** to develop a plan of action for control and prevention; coordinate statewide access to and availability of screening, treatment and follow-up services and establish mechanisms to assure all components of the plan are implemented timely and appropriately.

2) **Public Education** to inform all men, women and children in Illinois about the importance of lifestyles in the reduction of morbidity and mortality rates of breast and cervical cancers; the locations of screening, treatment and follow-up services and the need to adhere to screening guidelines and follow-up recommendations.

3) **Professional Education and Practice** to focus on timely and appropriate screening, tests, treatment and follow-up that are done with regard to cultural sensitivity.

4) **Quality Assurance** to concentrate on technical procedures, communication and follow-up with regard to obtaining, reading, interpreting and reporting results of each mammogram and Pap smear.

5) **Surveillance** to assess current state-of-the-art capabilities and to ensure that mechanisms are in place to identify and respond to changes in the subgroups who are most at risk.

6) **Evaluation** to determine if the Plan is achieving the desired results of an increase in the number of women who are screened, treated and followed on a timely basis; the identification of breast and cervical cancers at an early stage and the reduction in the morbidity and mortality rates of breast and cervical cancers.

The coalition will consist of members of public, private, professional, voluntary and consumer groups located throughout Illinois. Once the Plan has been completed, Illinois will seek funding from CDC and to support implementation of the Plan that will put Illinois in a leadership role in meeting the *Healthy People 2000* objectives of reducing the morbidity and mortality rates for breast and cervical cancer.

Cardiovascular Disease—The mission of the Cardiovascular Disease Prevention Program is to reduce heart disease morbidity and premature mortality by helping counties develop an ongoing system of heart health services and to involve citizens in risk reduction activities. Further, the statewide program addresses the disparate age-adjusted mortality and morbidity rates due to heart disease between whites and minorities.

The program funds 74 local health department (LHD) cardiovascular programs that coordinate existing services; develop additional services if needed; create awareness; motivate the public to know their risks and act to reduce their risks; assist high-risk adults to bring under control and to maintain control of their blood pressure and cholesterol levels and assist smokers to quit. All program objectives are directed at achieving the *Healthy People 2000* objectives.

Diabetes—The Department has received funding from CDC to establish programs in four LHDs that address complications of diabetes through education, control of blood sugar levels and diagnostic eye examinations. Diabetics who learn to control their blood sugar levels reduce their risk of complications such as diabetic retinopathy, lower extremity amputations, hypertension, end-stage renal disease, vascular disease, impotency.

Hearing—The Hearing Aid Consumer Protection Program promotes the benefits of hearing health care and protects the public from fraudulent dispensing practices. The program maintains a registry of licensed dispensers, conducts licensing examinations, makes periodic inspection visits to dispensers, manages the provision of continuing education to licensed dispensers, responds to consumer complaints and inquiries and ensures review of violations of the Hearing Aid Consumer Protection Act in the sales of hearing aids. The program provides hearing health care outreach programs to consumer groups, health departments and social service agencies that serve senior citizens.

Nutrition—Nutrition activities provide sound nutrition information to persons with or at risk for arthritis, cancer, diabetes, heart disease and stroke. The nutrition staff provide technical assistance and consultation to professional staff within the Department and other state and local agencies, organizations, and institutions. For example, results from a 1991 survey of 733 Department employees became the basis for nine workshops offered across the state on how to increase the consumption of fruits and vegetables. Nutrition staff also support the Commodity Supplemental Food Program (CSFP), which provides food to low income elderly, by program monitoring and training nutrition aids and local agency staff.

Renal Disease and Hemophilia—The Chronic Renal Disease and Hemophilia Programs determine eligibility of applicants seeking to receive payment for lifesaving treatments such as renal dialysis and antihemophilic factor. In fiscal year 1992, the Chronic Renal Disease Program reviewed an estimated 4,000 applications and financially evaluated 2,426 cases; 1,115 received financial assistance. In fiscal year 1992, the Hemophilia Program reviewed and financially evaluated 167 applications; 71 received assistance.

Table 3

ADULT AND SENIOR HEALTH

Target Populations and Recipients

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
TARGET POPULATIONS						
Illinois residents having certain conditions:						
Alzheimer's Disease	111,000	147,700	170,000	180,000	185,000	214,000
Breast Cancer	2,166	7,400	7,600	7,800	8,000	10,000
Cervical Cancer	2,400	2,600	2,800	3,000	3,200	6,000
Cardiovascular Disease	3,429,000	3,462,900	3,465,600	3,468,000	3,470,700	3,600,000
Diabetes	571,530	577,150	577,600	578,000	578,450	581,450
Hemophilia	795	848	900	925	950	1,172
Renal Disease	7,600	8,000	8,300	8,500	8,700	10,209
Hearing Loss[1]	866,160	874,200	881,400	889,200	897,000	1,200,000
RECIPIENTS						
Illinois residents with certain conditions who receive services:						
Alzheimer's Disease	6,717	7,800	8,500	9,148	10,062	25,000
Cardiovascular Disease	64,834	62,646	70,000	125,000	140,000	200,000
Diabetes[2]	3,762	3,859	1,383	2,383	3,883	5,000
Hemophilia	100	78	71	80	85	119
Renal Disease	1,047	1,094	1,115	1,165	1,215	1,449
Hearing Loss[3]	60,935	65,548	66,679	67,000	68,000	72,000

1. Estimated number of Illinois residents 65 years of age or older suffering from loss of hearing.
2. The total number recipients decreased in FY92 due to lack of medical providers.
3. This data reflects hearing aids dispensed.

Program Effectiveness

Alzheimer's Disease—The Alzheimer's Disease Program reviews and approves continuation applications annually for two regional centers: Rush Alzheimer's Disease Center located at Rush-Presbyterian-St. Luke's Medical Center and Southern Illinois University Center for Alzheimer's Disease and Related Disorders located at Southern Illinois University School of Medicine. The two centers have received general revenue funding since February 1987. Approximately 25 applications from researchers are received and reviewed annually by the Alzheimer's Disease Advisory Committee. Fifty-three researchers have received funds since the program's inception in July 1988. The program also coordinates a public awareness campaign for income tax contributions to the Alzheimer's Research Fund.

Cancer—The Illinois Cervical Cancer Control and Demonstration Project began in the fall of 1986 using a combination of multiple intervention methods for integration of follow-up activities into the regular daily flow of a Chicago Department of Health Neighborhood Health Center (NHC). These methods included a computerized tracking system which provides a systematic coordination of patients' follow-up activities; patient reminders; flow charts to inform physicians on current patients' Pap smear status and a bilingual breast and cervical cancer educational component.

Cardiovascular Disease—Approximately 63,000 identified hypertensives in Illinois were monitored, encouraged and guided toward control of their disease during fiscal year 1991. Increased hypertension control continued to reduce the number of deaths due to cardiovascular disease. Addressing hypertension is only a small segment of a complete cardiovascular risk reduction program. Other factors that must be addressed include elevated cholesterol levels and smoking cessation.

Diabetes—The Department uses CDC funds to support four LHDs that address complications of diabetes through education, control of blood sugar levels and diagnostic eye exams. During fiscal year 1992, 1,052 persons with diabetes received education programs regarding the necessity of obtaining routine ophthalmologic, podiatric, cardiovascular care and information on complications of diabetes including risk-behaviors and preventive self-management techniques and procedures. Staff gave diagnostic eye examinations to 1,383 persons with diabetes and treated 328 persons for diabetic eye disease.

Hearing—The Hearing Aid Consumer Protection Program sponsors presentations for consumer and social service agency personnel on hearing health care, hearing aids, purchasing rights and guarantees, medical alternatives and recourse via the Hearing Aid Action Line. The action line has resulted in fair and equitable responses to consumer complaints regarding hearing aid sales. Since the enactment of the Hearing Aid Consumer Protection Act (effective November 1, 1983), 31 dispensers have had their licenses either revoked or applications denied for dishonest dispensing practices.

Table 4

ADULT AND SENIOR HEALTH

Outcome Objectives and Actual Performance

	Actual 1990	Actual 1991	Actual 1992	Estimated 1993	Projected 1994	Projected 2000
MORTALITY RATES[1]						
Breast cancer						
outcome objective	20.6	20.6	20.6	20.6	20.6	20.6
actual performance	18.9	NA	NA	NA	NA	NA
Cervical cancer						
outcome objective	1.8	1.7	1.6	1.5	1.4	1.3
actual performance	1.8	NA	NA	NA	NA	NA
Diabetes						
outcome objective	18.1	17.5	17.0	16.5	16.0	13.0
actual performance	19.6	NA	NA	NA	NA	NA
Heart disease						
outcome objective	307.0	280.0	260.0	240.0	220.0	100.0
actual performance	307.0	NA	NA	NA	NA	NA

1. Per 100,000 population.

Hemophilia—Because of the financial assistance from this program, the University of Illinois at Chicago's Division of Specialized Care for Children (DSCC), the Department of Public Aid (IDPA) and private insurers, Illinois hemophilia patients are able to receive the quality care required to live a more normal life.

Nutrition—The Nutrition Services Section surveyed the current dietary habits of Department employees and identified low intakes of fruits and vegetables. To address the need to increase fruit and vegetable in the diet and reduce fat, the program conducted a series of workshops on improving eating habits. CSFP continues to expand the number of seniors that receive supplemental foods and nutrition information. Currently, 7000 seniors participate in the program.

Renal Disease—Because of the financial assistance from this program and IDPA, Medicare and private insurers, the Illinois renal dialysis patients are able to continue receiving dialysis treatments necessary for the patient to live. Without the program's assistance with the cost of dialysis some of these patients would be forced to receive Public Aid, resulting in costs to the state approximately three times more per patient.

Assurances

Interagency Cooperation

Cooperation and coordination with other state agencies is maintained through five nonvoting members of the Alzheimer's Advisory Committee who represent IDPA, the departments of Rehabilitation Services (DORS), Mental Health and Developmental Disabilities (DMHDD), Aging (DOA) and the Guardianship and Advocacy Commission. The Department is also represented on the Governor's Task Force on Alzheimer's Disease.

The Cancer, Cardiovascular Disease and Diabetes Programs cooperate with LHDs and other appropriate agencies such as the American Heart Association, the American Diabetes Association and the American Cancer Society.

The Hearing Aid Consumer Protection Program cooperates actively with the following state agencies: DMHDD, DOA, DORS, DSCC, IDPA, the Illinois Attorney General and the Department of Children and Family Services. These agencies advise the Department on program matters; disseminate Department generated information; and help counsel the hearing impaired and the general public on medical, educational, psychological, social and legal factors that affect access to hearing health care.

The Hemophilia Program cooperates with IDPA and DSCC. The Department establishes the policy for payment of antihemophilic factor and the price, which is also honored by IDPA. The Department pays for antihemophilic factor for all patients not eligible for IDPA. DSCC pays for comprehensive examinations and certain other charges for patients younger than 21 years of age; the Department pays for comprehensive and outpatient services for patients 21 years of age and older.

The Renal Disease Program is a cooperative effort between the Department and IDPA. After applications are medically approved by the Department, Public Aid eligible applications are referred to IDPA. Bills submitted by dialysis facilities to IDPA cannot be paid without patient eligibility notification by the Department. The Renal Disease Program pays the provider according to the Medicare composite rate.

Family Impact

Five family members of Alzheimer's victims serve on the 21-person Alzheimer's Advisory Committee. Family members of Alzheimer's victims receive counseling and other support services. The growing Network of Primary Providers established by the Alzheimer's Disease Assistance Centers throughout the state is resulting in increased access to services for Alzheimer's patients and their family members.

Integrating and expanding nutrition activities into chronic disease programs is beneficial to both individuals and families since the major causes of morbidity and mortality are largely controlled by lifestyle factors such as diet, exercise and preventive health practices. The 1988 Surgeon General's Report on Nutrition and Health reported that eating patterns may affect long term health more than any other personal choice for the two out of three Americans who neither smoke nor drink. To be most effective, nutrition activities address both individuals and families.

Education regarding the availability, benefit and acquisition of good hearing health care can assist hearing impaired citizens in maintaining communication with their families, thereby reducing stress, frustration and isolation. All families benefit from the availability of educational materials and opportunities concerning all the chronic diseases addressed by this program. Reduced morbidity and mortality contribute to an improved quality of life for all families.

Recommended Changes to Program

Most private or public insurance carriers do not reimburse for dietary guidance and nutrition education. Lack of reimbursement remains a barrier to availability of nutrition services. The Department needs to explore ways to assist in establishing billing systems or other funding mechanisms for nutrition services within publicly funded primary health care systems.

Health promotion and behavior risk assessments are important tools in chronic disease prevention and control. Plans for chronic disease control programs should address arthritis and asthma which affect major segments of the general population.

Outside agencies such as the Illinois State Medical Society, the American Diabetic Association, the Association of American Diabetes Educators, Illinois Cancer Council, American Heart Association, the National Heart/Lung/Blood Institute, National Cholesterol Education Program, National High Blood Pressure Education Program, Illinois Nurses Association, Illinois Dietetic Association, American Cancer Institute, Community Primary Health Care Agencies, local hospitals, local industry, and third parties providing reimbursement services must be encouraged to expand their cooperative efforts through the Adult and Senior Health programs.

In fiscal year 1994, the Divisions of Health Promotion and Adult and Senior Health have been merged into one division, the Division of Health Promotion.

Legal Citations

Alzheimer's Disease Assistance Act, 410 ILCS 405/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 6951 et *seq.*)

Alzheimer's Disease Research Act, 410 ILCS 410/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 6901 *et seq.*)

Hearing Aid Consumer Protection Act, 225 ILCS 50/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111, ¶ 7401 *et seq.*)

Hemophilia Act, 410 ILCS 420/0.01 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 2900 *et seq.*)

High Blood Pressure Control Act, 410 ILCS 425/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 2601 *et seq.*)

Public Health Service Act, CDC cooperative agreement, § 301(a) 42 USC 241 (a) of the Public Health

Renal Disease Act, 410 ILCS 430/0.01 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 22.30 *et seq.*)

Social Security Amendment of 1972, PL 92-603

Program Title: **Refugee and Immigrant Health Services**

Goal

To provide health screening to refugees and immigrants settling in Illinois and identify and treat health problems, thus improving quality of life, reducing morbidity and premature mortality and enabling self-sufficiency and resettlement.

Needs Assessment

The enactment of the Refugee Act of 1980 revised the United States refugee admissions policy and authorized uniform resettlement assistance for all refugees, including the provision of medical assistance to any refugee for a period of 36 months. The Act defines "refugee" as follows: "The term 'refugee' means any person who is outside any country of such person's nationality or, in the case of a person having no nationality, is outside any country in which such persons last habitually resided, and who is unable or unwilling to return to, and is unable or unwilling to avail himself or herself of the protection of that country because of persecution or a well founded fear of persecution on account of race, religion, nationality, membership in a particular social group or political opinion . . ."(8 USC 1101 (42)). This Act created refugee health screening programs and authorized reimbursement for refugee health services. However, since 1980, the period of eligibility has shortened several times. For fiscal year 1993, the eligibility period was eight months.

The Illinois Department of Public Health's records indicate that 63,941 refugees have arrived in Illinois since 1979; in 1992, 5,716 refugees settled in Illinois. In fiscal year 1992, 3,257 refugees were screened throughout the state. The most prevalent health problems found among those screened were: significant tuberculin reactors (skin tests)—40 percent; abnormal ova and parasite results—16 percent; positive Hepatitis B carrier or disease results—5 percent; and serious dental problems—10 percent. Identification of dental problems is limited to sites with the capability to provide these services.

The Immigration Reform and Control Act (IRCA) of 1986 allowed many aliens who had been living in the U.S. illegally to obtain lawful resident status and eventually qualify for citizenship. As a result, an estimated 150,560 immigrants in Illinois became eligible to receive all public health services provided by local health departments (LHDs) during a five-year period ending in 1993. Under the State Legalization Impact Assistance Grant (SLIAG), these LHDs are reimbursed for services provided to immigrants eligible for amnesty. This reimbursement is based on a ratio formula determined by figures from the Department of Health and Human Services. It is estimated that the caseloads of applicable programs increased by approximately 1.7 percent due to the addition of the newly legalized population.

Program Activities

General Overview

The Refugee and Immigrant Health Services program is administered by the Division of Health Promotion within the Office of Community Health. Health assessment and referral services improve the general health

of the refugee and immigrant populations in the state. The Department focuses on those health problems that may impede effective resettlement and prevent social and economic self-sufficiency. Ten local health agencies serve as screening centers to provide health services to refugees in Illinois: Adams County Health Department; Alton Family Service & Visiting Nurses Association; Chicago Department of Health; Cook County Department of Public Health; Frances Nelson Health Center—Champaign; Jackson County Health Department; Rock Island County Health Department; St. Francis Medical Center/Harrison Homes Clinic—Peoria; Springfield Department of Public Health and Winnebago County Health Department. Many agencies refer clients to health care providers in their areas to help with screening and follow-up. Virtually every officially arriving refugee is informed of the availability of health screening services through the combined efforts of the screening center staff; voluntary agency caseworkers; staff within the organization responsible for a refugee's effective resettlement and sponsors—usually individuals or religious organizations—that ease a refugee's transition into the community.

Besides overseeing the agencies that provide services to refugees, the Department prepares and submits to CDC grant applications for funding, provides case management and coordinates the activities of health agencies approved by both the Immigration and Naturalization Service and the Department to provide services to undocumented immigrants seeking legalization. Through SLIAG, these agencies perform the medical examinations and follow-up care required for undocumented immigrants to become eligible legalized aliens and receive temporary residency status.

Program Data

The number of refugees screened in Illinois is increasing. The ethnic composition of the Illinois refugee population, reflecting the evolving international political climate, has changed significantly. In fiscal year 1987, 47.5 percent of the refugees were from Southeast Asia and 33 percent from Eastern Europe; whereas, during fiscal year 1992, 37 percent of the refugees were Southeast Asian and 50 percent Eastern European. Table 1 shows the number of the target immigrant population receiving medical services. From fiscal year 1985 to fiscal year 1990, 95,708 or 63.7 percent of the estimated 150,560 immigrants were served.

Table 1

REFUGEE AND IMMIGRANT HEALTH SERVICES

Target Population, Recipients and Activity Measures

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
TARGET POPULATION						
New refugees in Illinois	7,149	4,231	5,722	7,000	7,000	7,000
RECIPIENTS						
Immigrants and refugees receiving medical screening	5,912	4,118	5,645	6,860	6,900	6,950
Immigrants and refugees who have						
(+) TB skin test	2,302	2,232	1,951	2,675	3,000	3,500
(+) Hep B test	94	80	70	56	69	69
ACTIVITY MEASURES						
Immunizations provided	1,312	1,595	1,610	1,420	1,449	1,459
Immunizations provided children less than 18 years of age	481	585	659	276	1035	1042

Program Effectiveness

The refugee program is making progress toward increasing the treatment of refugee health problems found during health screenings. The program seeks to increase the therapy and treatment rate for refugees who test tuberculosis positive. The program also seeks to increase the vaccination rate for known personal contacts of refugees who are Hepatitis B carriers. Table 2 illustrates the refugee program's outcome objectives and actual performance regarding tuberculosis and Hepatitis B.

Since the one-year amnesty period for undocumented immigrants began in May 1987, a vast majority of the expected 150,560 eligible aliens have requested medical examinations and subsequent treatment as part of the legalization process. As a result, SLIAG has awarded more than $3 million to approximately 35 LHDs as reimbursement for the costs associated with providing examinations and treatment.

Table 2

REFUGEE AND IMMIGRANT HEALTH SERVICES

Outcome Objectives and Actual Performance

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
Therapy and treatment rate for immigrants and refugees who test TB positive[1]						
outcome objective	75	75	80	90	95	95
actual performance	70	75	85	NA	NA	NA
Vaccination rate for the contacts of immigrant and refugee Hepatitis B carriers[1]						
outcome objective	75	75	80	80	85	85
actual performance	65	70	75	NA	NA	NA

1. Percent.

Assurances

Interagency Cooperation

To ensure that refugees and immigrants receive proper health care, division staff work closely with the ten local health agencies previously mentioned:

- Adams County Health Department
- Alton Family Service and Visiting Nurses Association
- Chicago Department of Health
- Cook County Department of Health
- Frances Nelson Health Center (Champaign)
- Jackson County Health Department
- Rock Island Public Health Department
- St. Francis Medical Center/ Harrison Homes Clinic (Peoria)
- Springfield Department of Public Health
- Winnebago County Health Department

The Department also works closely with Mt. Sinai Hospital in Chicago where refugees and immigrants from the Commonwealth of Independent States (formerly the Soviet Union) are provided medical services.

In addition division staff participate with representatives from the following organizations who meet regularly in a cooperative effort to share information on policy, funding and employment-related issues for immigrants and refugees:

Adult Learning Resource Center
Alternatives, Inc.
American Somalian Organization for Relief and Development
The Ark
Asian Human Services
Assyrian Universal Alliance Foundation
Cambodian Association of Illinois
Catholic Charities of the Archdiocese of Chicago
Catholic Charities of Metropolitan Chicago
Catholic Charities of Springfield
Catholic Diocese of Rockford
Chicago Board of Education
Chicago Coalition for Immigrant and Refugee Protection
Chicago Commission on Human Relations
Chicago Department of Health
Chinese American Service League
Chinese Mutual Aid Association
Cook County Department of Health
East Central Illinois Refugee MAA Center
Elgin YWCA
Episcopal Diocese of Chicago
Ethiopian Community Association of Chicago
Exodus World Service
Filipino American Council of Chicago Social Service and Human Resources, Inc.
F.R.E.E. (Friends of Refugees from Eastern Europe)
HIAS (Hebrew Immigrant Aid Society)
Hillel CAYS (Community Activities Service)
Illinois Board of Education
Illinois Department of Children and Family Services
Illinois Department of Mental Health and Developmental Disabilities
Illinois Department of Public Aid
Interchurch Refugee and Immigration Ministries
Jewish Family and Community Services
Jewish Federation
Jewish Federation (Washington, D.C.)
Kaplan JCC (Jewish Community Center)
Jewish Vocational Service
Korean American Community Services
Lao American Community Services
Literacy of Chicago
Lutheran Office for Governmental Affairs (Washington, D.C.)
Lutheran Social Services of Illinois
Michael Reese Hospital and Medical Center
National Conference of Christian and Jews, Inc.
Nghia Sinh International, Inc.
Polish Welfare Association
Public Health and Education Association
Resource and Information Center
Rock Valley College
Settlers' Housing Service, Inc.
The Shalom Center
Southeast Asia Center
Synapsea Asian Organizing Program
Touhy Health Center
Travelers and Immigrants Aid
Truman College
University of Illinois Chicago
U.S. Department of Health and Human Services—Administration for Children and Families
U.S. Immigration and Naturalization Service
Vietnamese Association of Illinois
World Relief Corporation
World Relief Corporation (DuPage County)

Family Impact

All programs described here promote the health and social well-being of refugee and immigrant families by striving to improve access to and availability of basic public health services and bilingual Assistance.

Recommended Changes

During fiscal year 1994, state refugee health coordinators will evaluate whether to recommend a nationwide certification and training program of bilingual medical staff. Otherwise, activities in all programs will remain basically unchanged until October 1, 1994 when SLIAG ceases.

Legal Citations

Immigration and Nationality Act, 8 USC 1101j(a)(42)

Immigration Reform and Control Act of 1986, 8 USC 1324(a)(245)

Refugee Act of 1980, 8 USC 1101

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Program Title: **Assistance to Survivors of Sexual Assault**

Goal

To reduce the emotional and physical trauma experienced by victims of sexual assault, to assure prosecution of offenders and to educate the public about sexual assault.

Needs Assessment

Every five minutes a woman is raped in the United States. Every two minutes a child is sexually abused. One in three females and one in six males will be sexually assaulted by the age of 18 years. According to Federal Bureau of Investigation statistics, 100,433 rapes and attempted rapes were reported to law enforcement officials in 1990. Unfortunately, the institutions, agencies and organizations designed to aid the victim and apprehend the offender become involved in only a fraction of these cases. The table listed below contain data sources that indicate an even larger number of individuals who are victims of sexual assault.

Table 1

ASSISTANCE TO SURVIVORS OF SEXUAL ASSAULT

Victims of Sexual Assault

Source	1990	1991
Uniform Crime Report (Federal Bureau of Investigation)	100,433	106,593
National Crime Survey (U.S. Department of Justice)	130,000	207,610
National Victims Center Survey (federally funded survey)	683,000	NA

Sexual assault victims need assistance for emotional trauma and possibly physical injury. They are at risk of sexually transmitted diseases, HIV infection and unwanted pregnancy. Unfamiliar and often unpleasant legal procedures may face these victims. They may need temporary shelter and assistance securing their own homes. Despite these needs, sexual assault victims often do not seek assistance because they are uncertain about how helpful or sympathetic people will be. Victims fear reprisal from the offender, hours of waiting and questioning by police and state's attorneys and further upset of their emotional and physical condition.

Sexual assault crisis intervention programs provide support and reassurance to the victim and help them seek medical care and legal assistance. Programs also promote more sensitive care by agencies and institutions committed to the needs of sexual assault victims. Additionally, education makes communities more aware of sexual assault and the needs of victims.

The Illinois Sexual Assault Survivors Emergency Treatment Act authorized the Department to establish standards, rules and regulations for: treatment, collection of evidence and hospital reimbursement for emergency services given to individuals who are not covered by an insurance policy or eligible for Public Aid.

During fiscal year 1993 the Department formed a Sexual Assault Treatment Task Force to review the Sexual Assault Survivors Emergency Treatment Program, which is mandated by the Sexual Assault Survivors Emergency Treatment Act (SASETA). The Task Force reviewed SASETA requirements for responding to sexual assault victims, SASETA costs and sources of funding, participants in the standard response to a sexual assault survivor and their communications, gaps in service delivery and duplication of services. During fiscal year 1994, the Task Force will analyze specific issues and recommend improvements that will clearly define the roles for medical response participants and improve service delivery. The issues to be analyzed are:

- access to and availability of treatment for sexual assault survivors
- clarification of reimbursement criteria and procedures
- confidentiality of a minor who is a sexual assault survivor
- continuing education of physicians and nurses who treat sexual assault survivors
- enforcement of participating hospital's Transfer Plan and Treatment Plan
- medical record requirements
- minimum standards for treatment of alleged sexual assault survivors
- pregnancy prevention information and medication provided at all hospitals
- protocols for the treatment of individuals sexually assaulted while institutionalized
- statewide uniformity of the Evidence Collection Kit
- use of the Evidence Collection Kit as an educational vehicle

Program Data

Table 2

ASSISTANCE TO SURVIVORS OF SEXUAL ASSAULT

Target Population, Recipients and Activity Measures

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
TARGET POPULATION						
Residents[1]	11,430,602	11,543,000	11,552,000	11,560,000	11,569,000	11,857,000
RECIPIENTS						
Survivors and significant others receiving services	10,265	10,304	13,694	14,000	14,500	21,679
Survivors hospital bills paid	1,053	879	1,341	1,440	1,630	2,332
ACTIVITY MEASURES						
Crisis centers funded	28	28	29	29	29	30
Advocacy hours	16,872	19,649	20,905	21,500	23,000	33,024
Counseling hours	39,936	41,139	47,244	49,500	51,000	67,952
Participants in community education	92,487	122,902	131,213	132,000	138,000	219,492
Participants in professional training programs	10,040	12,262	12,442	13,000	13,500	19,083

1. This target population was selected because all people are vulnerable to sexual assault and all residents of Illinois are the intended audience for education about sexual assault. The target population for direct services is all sexual assault victims and their significant others. In 1991, 6,399 cases of sexual assault were reported in Illinois.

Program Activities

General Overview

The Division of Health Promotion, within the Office of Community Health, administers the Preventive Health and Health Services Block Grant (PHHS). In federal fiscal year 1982, the Division began giving PHHS Rape Crisis and Rape Prevention funding to the Illinois Coalition Against Sexual Assault (ICASA), a nonprofit corporation. Since July 1, 1986, the Department has provided ICASA with General Revenue Funds.

ICASA initiates public policies affecting sexual assault victims and monitors, plans and develops services through its staff, standing committees and Governing Body. The Department contracts with ICASA to fund, monitor and provide technical assistance to community-based sexual assault centers that provide comprehensive sexual assault services. The services provided at 29 such centers include 24-hour crisis intervention, individual and group counseling, advocacy for the victim within the medical and criminal justice systems, information and referral, prevention programs, public education and professional training.

Program Effectiveness

The Department provides payment for emergency treatment of victims of sexual assault. Hospitals with approved Sexual Assault Treatment Plans or Sexual Assault Transfer Plans are reimbursed for emergency treatment of survivors who are not covered by public or private insurance.

Table 3

ASSISTANCE TO SURVIVORS OF SEXUAL ASSAULT

Outcome Objectives and Actual Performance

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
ICASA clients who report sexual assaults to law enforcement officials[1]						
outcome objective[2]	85	75	75	80	80	85
actual performance[2]	75	84	77	NA	NA	NA
Reported sexual assaults that result in prosecutions[1]						
outcome objective[2]	30	30	35	37	38	40
actual performance[2]	28	35	37	NA	NA	NA
Prosecutions for sexual assault that result in convictions[1]						
outcome objective[2]	45	55	40	45	50	70
actual performance[2]	66	50	45	NA	NA	NA

1. Percent.
2. In recent years, the client load served by the local crisis centers has included a larger percentage of victims of acquaintance rape and marital rape. These victims are reluctant to report the assault to law enforcement authorities. When reported, these cases are less likely to be accepted for prosecution. When prosecuted, these cases are less likely to win convictions. In light of this, there have been, and may continue to be, fluctuations in outcome with occasional downward trends. However, ICASA expects the reporting, prosecution and conviction of sexual assailants to increase as a result of its expanded efforts to provide education, training, direct crisis intervention and information.

Assurances

Interagency Cooperation

Department and ICASA staff work closely with the Illinois Attorney General, Department of State Police, Department of Children and Family Services, Illinois Department of Public Aid, and state's attorneys.

Family Impact

Though difficult to measure, current research indicates that sexual assault crisis services mitigate stressful circumstances for both the survivor and their family.

Recommendations for Changes

ICASA expects to make recommendations for change after the Sexual Assault Treatment Task Force completes the analysis of the issues previously listed in "**Need Assessment**" (see p. 44).

Legal Citations

Omnibus Budget Reconciliation Act of 1981, PL 97-35 (Federal Block Grant legislation)

Sexual Assault Survivors Emergency Treatment Act, 410 ILCS 70/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 87-1 *et seq.)*

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Program Title: **Oral Health**

Goal

To prevent and control oral disease.

Needs Assessment

Oral diseases are a prevalent public health problem. Diseases of the oral cavity, found in all age groups, involve all of the surrounding tissues—the teeth, periodontium, tongue, palate, tissues of the soft palate and oral pharynx. The types of disease that afflict the mouth, besides dental decay, range from simple inflammations to severe infections, tissue proliferations and malignancies. Specific oral conditions include dental caries (cavities), periodontitis, malocclusion, traumatic injuries, cleft lip and palate and oral cancer. The oral health problems of the homebound, handicapped, mentally impaired and other special population groups are increasing in numbers. The increasing proportion of the population that attain geriatric status also presents a greater need for programs in oral health prevention and education.

Dental caries afflict 95 percent to 98 percent of the adult population, and approximately 50 percent of the school children in Illinois. Periodontal diseases affect more than 60 percent of adults and 50 percent of adolescents in Illinois. These disease entities account for 69 percent of people ages 35 through 44 who have experienced tooth loss and the subsequent health problems including infection and more serious systemic disease. The loss of teeth results in the need for costly prosthetic appliances.

Cancer of the oral cavity, which attacks approximately 30,000 U.S. residents each year, claims more than 11,000 lives annually. Recent scientific evidence links smokeless tobacco use with increased risk for oral cancer. The use of smokeless tobacco products has increased dramatically in recent years, as advertising campaigns have been directed at youth. Many children younger than 17 years of age suffer from problems related to malocclusion and craniofacial anomalies; many become facially crippled unless they receive early and appropriate treatment.

Baby bottle tooth decay (BBTD) is a rampant form of severe dental decay caused by improper feeding practices. During 1992, 850 infants were screened; more than 17 percent had BBTD and 76 percent of those with BBTD had not yet received needed dental treatment.

The high prevalence of oral disease is compounded by the fact that less than 60 percent of Illinois residents visit a dentist on an annual basis. Financial barriers and limited access to oral health care create more demands upon public agencies for alleviation of these problems. This is especially true for minority populations, school children from low-income families, the geriatric population and other special population groups.

Program Activities

General Overview

The Division of Dental Health, within the Office of Community Health, provides Oral Health services. The division has established statewide oral health prevention programs to prevent and control oral disease through organized community efforts. These program activities include community water fluoridation, fluoride mouthrinse programs, dental sealant programs, baby bottle tooth decay programs, craniofacial anomaly programs, orofacial injury programs, smokeless tobacco programs and programs for special population groups.

The Department made prevention and control of oral disease a priority in fiscal year 1993, significantly increasing the number of dental sealant programs. The Department continues the fluoride mouthrinse programs for children, although Illinois residents have benefitted from the use of fluoride because of the implementation of community water fluoridation and an increase of supplemental fluorides available in toothpastes, mouthrinses and tablets.

Program Data

Table 1

ORAL HEALTH

Target Populations, Recipients and Activity Measures

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
TARGET POPULATIONS[1]						
Children 0 to 14 years of age	2,494.1	2,528.0	2,540.0	2,553.0	2,564.0	2,481.8
Residents	11,430.6	11,543.0	11,552.0	11,560.0	11,569.0	11,857.0
RECIPIENTS[1]						
Children in dental sealant programs	2.7	2.9	2.7	15.0	20.0	70.0
Children in fluoride mouthrinse programs	90.5	90.3	87.4	87.0	87.0	87.0
Residents receiving optimally fluoridated water	7,900.0	8,039.2	8,447.7	8,670.0	8,900.0	10,078.5
ACTIVITY MEASURES						
Dental sealant programs	5	5	5	26	26	50
Dental sealants provided[1]	15.2	16.2	18.0	60.0	80.0	280.0
Mouthrinse treatments provided[1]	3,258.9	3,249.0	3,148.0	3,132.0	3,132.0	3,132.0

1. Count in thousands.

Process Objectives

1. Develop a protocol and statewide implementation plan for the pilot Refugee Oral Health Project by June 30, 1994.

2. Evaluate results of Illinois' Baby Bottle Tooth Decay (BBTD) survey and develop a statewide BBTD prevention project by June 30, 1994.

3. Analyze survey data and formulate a statewide plan for the integration of oral health into appropriate Maternal and Child Health programs by June 30, 1994.

4. Develop a protocol for an orofacial injury control program by June 30, 1994.

Program Effectiveness

Water fluoridation is the most effective public health measure available to prevent and control tooth decay (cavities). Since Illinois is one of seven states that has a mandatory fluoridation law, Illinois residents experience significantly less dental decay. Before community water fluoridation began in the mid-1940s, the average child had 10 or more decayed tooth surfaces. In contrast, the average child in 1992 had slightly more than three tooth surfaces decayed. The health benefits of water fluoridation are most beneficial when the fluoride level in water is maintained within the optimal range. During 1992, approximately 73 percent of Illinois residents—almost all living in residences connected to public water supplies—received the dental health benefits of drinking optimally fluoridated water (Figure 1).

School fluoride mouthrinse programs are the second most prevalent community method to prevent dental caries. Studies show that school-based, weekly, 0.2 percent sodium fluoride mouthrinse programs can result in cavity reductions of between 20 and 50 percent. During 1992, fluoride mouthrinse programs were conducted in 461 schools in 64 Illinois counties with a combined enrollment of 87,458 Illinois school children participating in these programs.

Table 2

ORAL HEALTH

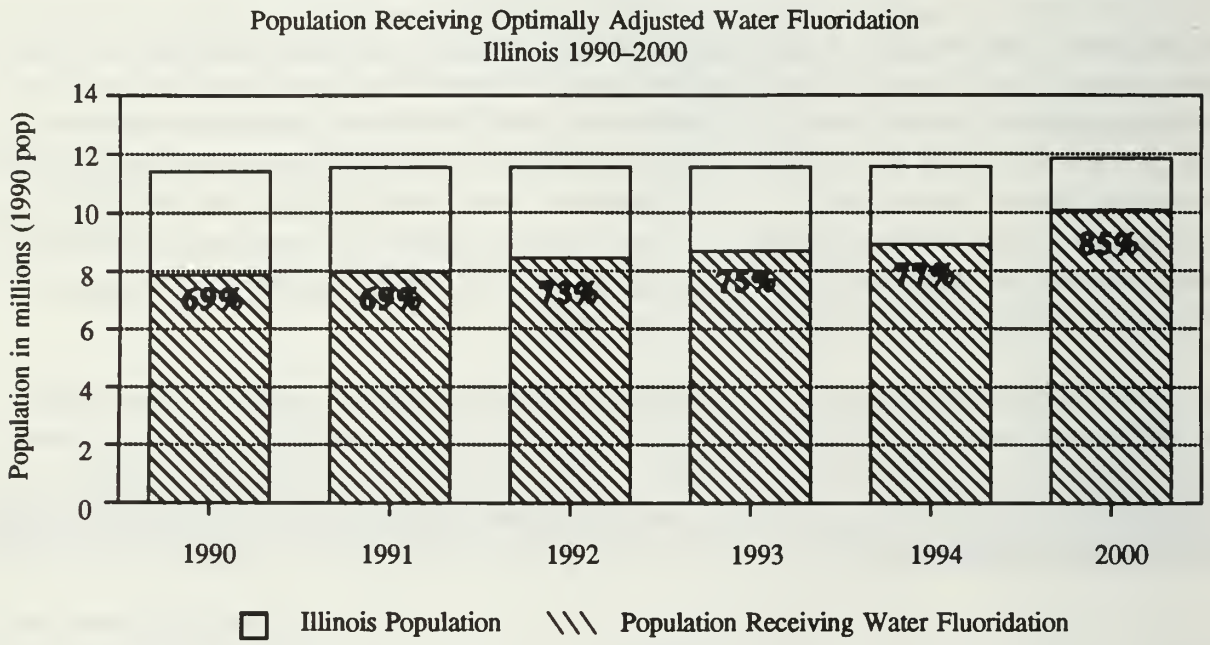
Outcome Objectives and Actual Performance

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
Children in dental sealant programs						
outcome objective	NA	NA	NA	15,000	20,000	70,000
actual performance	2,731	2,906	2,664	NA	NA	NA
Children in fluoride mouthrinse programs						
outcome objective	NA	NA	87,000	87,000	87,000	87,000
actual performance	90,526	90,252	87,458	NA	NA	NA
Residents receiving optimally fluoridated water[1]						
outcome objective	NA	NA	8,664.0	8,670.0	8,900.0	10,078.5
actual performance	7,900.0	8,039.2	8,444.7	NA	NA	NA

1. Count in thousands.

Dental sealant programs, when combined with the appropriate use of fluorides, can virtually eradicate dental decay. Dental sealants are "plastic coating" applied to primary and permanent teeth which immunize the teeth from dental decay. During 1992, five dental sealant programs were conducted in Illinois for 2,664 high-risk children. These preventive programs provide dental sealants to high-risk groups of children of low socioeconomic status and, when combined with the appropriate use of fluorides, will practically eliminate dental caries from this target population.

Figure 1



Source: IDPH, Division of Dental Health

The craniofacial anomaly program provided information to families of infants born with cleft lip and/or cleft palate. Since the program's inception in 1986, the division has sent packets of educational materials and referral information to parents of 1,215 infants born with anomalies.

Preventive oral health is a vital health issue in Illinois, with 73 percent of its population receiving optimally fluoridated water; 87,458 children participating in fluoride mouthrinse programs; children from five counties participating in dental sealant programs and a variety of dental health educational programs for special populations being conducted throughout the state. Data from national caries surveys conducted in 1979 through 1980 demonstrated a general decline in caries prevalence among school children. Even greater caries reduction rates are noted when these data are compared with survey results collected about 10 years earlier. Dental prevention programs, taking place in Illinois schools and communities, provide for significant improvement in the oral health of young people and adults in Illinois.

Assurances

Interagency Cooperation

The statewide water fluoridation program is coordinated with the Illinois Environmental Protection Agency and with city and county officials in Illinois. The dental sealant programs are conducted in cooperation with

local health departments, Illinois Department of Public Aid, Healthy Kids program, Delta Dental Plans of Illinois and local professional organizations. The Baby Bottle Tooth Decay Prevention project is a cooperative effort with Western Illinois University and geriatric projects are conducted with the University of Illinois Chicago, Illinois Geriatric Education Center. The craniofacial anomaly program is coordinated with the Illinois Association of Craniofacial Teams.

Family Impact
Good oral health contributes to healthy smiles, improved speech and nutrition and enhanced self-esteem. By promoting oral health as an integral component of total health, the Division of Dental Health promotes and strengthens the health of the families of Illinois.

Recommended Changes

The Division of Dental Health plans to conduct a primary prevention program regarding baby bottle tooth decay in Illinois. The division plans to maintain the number of participants in the fluoride mouthrinse program, and to increase the number of dental health educational programs for special population groups, including the refugee and geriatric populations and infants born with craniofacial anomalies. The division will investigate other programs and activities beyond its current scope to further reduce the incidence of orofacial injuries in Illinois and to integrate oral health into Maternal and Child Health programs. The division plans to monitor monthly water sample reports for compliance with the fluoridation law; prepare quarterly and annual compliance reports and provide information on the health benefits of fluoridation to increase the number of Illinois residents who receive the benefits of fluoridated water.

Legal Citations

Civil Administrative Code of Illinois, 20 ILCS 2310/55.02, 55.05, 55.23, 55.27 (Ill. Rev. Stat. 1991, ch. 127, ¶ 55.02, 55.05, 55.23, 55.27)

Critical Health Problems and Comprehensive Health Education Act, 105 ILCS 110/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 122, ¶ 861 *et seq.*)

Nursing Home Care Act, 210 ILCS 45/1-101 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 4151-101 *et seq.*)

Public Water Supply Regulation Act, 415 ILCS 40/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 121a *et seq.*)

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CHAPTER III

OFFICE OF HEALTH PROTECTION

Introduction

Mission

To protect individuals from infectious diseases; environmental exposures; toxic substances and dangers related to contamination of food, drugs and dairy products.

Summary of Responsibilities

General Overview

To accomplish its mission the Office of Health Protection (OHP) administers programs that reduce the spread of reportable infectious diseases and subsequent morbidity and mortality; reduce or eliminate exposure to environmental hazards and ensure a safe, wholesome and nutritious food supply. OHP coordinates activities related to emergency preparedness; responds to situations that affect the health and well-being of Illinois citizens and has direct responsibility for the Plumbing Program, which is discussed in detail in a subsequent section of this chapter.

Methods of Carrying Out Responsibilities

OHP develops policies, procedures, guidelines, rules and regulations necessary to administer the various programmatic responsibilities. It purchases and supplies to public clinics immunizing agents and antibiotics for treatment of sexually transmitted diseases; provides transportation for and testing of specimens and distributes educational materials. Consistent with the *Healthy People 2000* objectives and the Department's commitment to delegate the provision of direct services to local health departments (LHDs), OHP is increasing financial support to LHDs through grant awards and is assuming a greater role in training, technical assistance and consultation.

Priorities

OHP has established the following priorities for fiscal years 1993 and 1994:

- reduce the spread of the human immunodeficiency virus (HIV) through continued education, counseling and testing programs

- reduce the spread of reportable infectious diseases through the continued provision of immunizing agents, antibiotics and educational materials
- prevent contamination of foods, drugs, medical devices and cosmetics through regulation, inspection and monitoring procedures
- reduce the incidence of personal disease and injury related to environmental factors
- provide essential laboratory testing services needed to support all public health programs

Fiscal Years 1992 through 1994 Budgets

The OHP budget for fiscal year 1992 supported five divisions and approximately 30 programs. Changes in both federal and state legislative mandates increased some program activity for fiscal year 1993 and will further increase program activity in fiscal year 1994. Two examples are programs to prevent and treat lead poisoning in children and to regulate tanning facilities. Costs for administering these programs will be offset somewhat by fees established for testing and licensure, respectively.

Divisions

The Office of Health Protection's components and their missions follow:

The ***Division of Environmental Health's*** mission is to reduce the incidence of disease and injury due to environmental factors and to reduce the incidence of injury associated with the use of equipment in regulated facilities. Administered programs are Asbestos Abatement, Lead Contamination Abatement and Control, Environmental Toxicology, Non-Community Water Systems, Private Sewage Disposal, Private Water, Vector Control, Structural Pest Control, Manufactured Housing, Mobile Home Parks, Migrant Labor Camps, Swimming Pools and Bathing Beaches and Youth Camps and Recreational Areas.

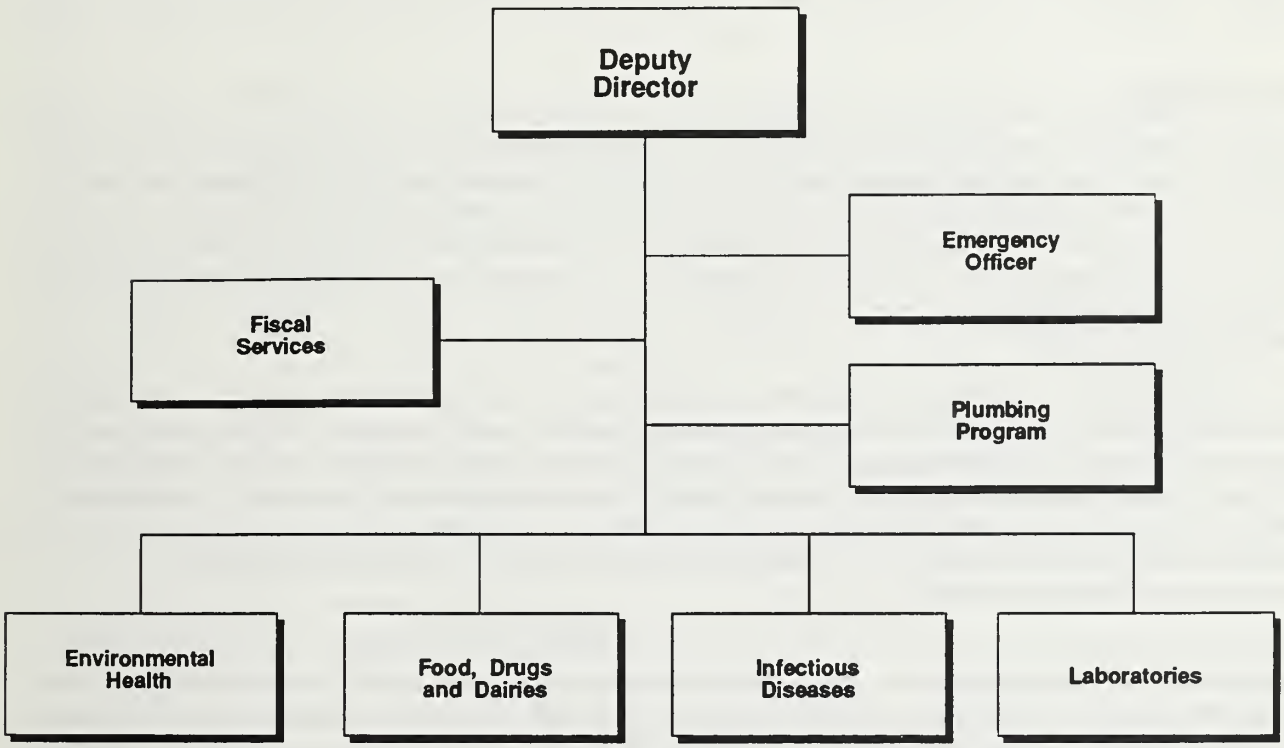
The ***Division of Food, Drugs and Dairies'*** mission is to ensure a safe, wholesome and properly labeled food, dairy, drug and cosmetic supply; to provide consumers with a listing of generically equivalent drug products at lower cost than specific brand names and to ensure the safety of tanning facilities. Administered programs are Dairy Regulation, Food Safety, Medical Device and Cosmetic Manufacturers and Tanning Facilities.

The ***Division of Infectious Diseases'*** mission is to reduce the spread of reportable infectious diseases and subsequent morbidity and mortality. Administered programs are AIDS (acquired immunodeficiency syndrome) /HIV, Communicable Diseases, Immunizations, Sexually Transmitted Diseases and Tuberculosis.

The ***Division of Laboratories'*** mission is to provide accurate, reliable and timely laboratory support for all Department programs and to assure the quality of services of private clinical and environmental laboratories through proficiency testing, training and consultation.

Figure 1

Office of Health Protection



Arbovirus Surveillance
Asbestos Abatement
Campground Licensing and Recreational Areas
Environmental Toxicology
Field Sanitation
Manufactured Housing
Migrant Labor Camps
Mobile Home Parks
Non-Community Public and Private Water Supplies
Pesticides
Private Sewage Disposal
Swimming Pool and Bathing Beaches
Youth Camps

Dairy Farm and Milk Processing Sanitation
Drug, Medical Device, Cosmetic Sanitation
Drug Product Selection (Generic Drugs)
Food Sanitation/Safety
Tanning Facilities

Acquired Immunodeficiency Syndrome (AIDS)
Communicable Disease (CD)
Immunization
Sexually Transmitted Diseases (STD)
Tuberculosis (TB)

Clinical Chemistry - Pediatric Blood Lead Analysis
Clinical Immunology - HIV Antibody Determination and Confirmation
Clinical Microbiology
Environmental Microbiology
Inorganic Chemistry
Newborn Metabolic Diseases Screening

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Program Title: **AIDS/HIV**

Goal

To reduce the spread of and morbidity and mortality associated with HIV (human immunodeficiency virus) infection.

Needs Assessment

Persons with acquired immunodeficiency syndrome (AIDS) and AIDS-related conditions have many medical, psychological and social needs. Throughout the course of the illness, persons with AIDS may require one or more acute care hospitalizations, home health care, homemaker care, ambulatory outpatient care and long-term or hospice care. In addition to the psychological and sociological problems associated with any fatal disease, often persons with AIDS are alienated and even estranged from the traditional support systems offered by friends and family members. Any system of care for persons with AIDS must be sensitive and responsive to these needs.

Persons most at-risk for AIDS are adult homosexual males, adult males having occasional homosexual contact, injecting-drug users (IDUs) and nonmonogamous sexually active persons. These persons require antibody counseling and testing programs. The demand for these services increases as greater numbers of individuals, especially nonmonogamous heterosexuals, identify themselves to be at risk. A significant proportion (18.1 percent) of persons who use the HIV counseling and testing sites are the "worried-well," or persons not at significant risk who are concerned they may be infected. It is important that these services be available to persons truly at risk.

The Centers for Disease Control and Prevention's (CDC) surveillance case definition of AIDS is HIV infected individuals in the late stages of the disease. CDC estimates there are from 10 to 50 infected individuals for every diagnosed case of AIDS. From 1981 through December 31, 1992, the Department received reports of 11,531 cases of HIV infection and 8,278 cases of AIDS among Illinois residents. This figure includes 5,875 cases reported from the city of Chicago (eighth highest among U.S. cities and 2,403 cases reported from 91 counties throughout Illinois. Illinois ranks sixth among all states in the number of AIDS cases reported (Table 1). Eighty-eight percent of cases reported are homosexually or bisexually active males and IDUs.

Table 1

AIDS/HIV

Cumulative Reported AIDS Cases by State[1]

Rank	State	Number of Cases	Rank	State	Number of Cases	Rank	State	Number of Cases
1	New York	50,985	4	Texas	17,363	8	Pennsylvania	6,967
2	California	46,818	5	New Jersey	14,702	9	Maryland	5,307
3	Florida	24,492	6	Illinois	8,278	10	Massachusetts	5,177
			7	Georgia	7,044			

1. From 1982 through December 31, 1992.

Racial and ethnic minority populations are overrepresented among AIDS cases. African-Americans comprise 36 percent and Hispanics comprise 12 percent of the reported AIDS cases; but they comprise only 14 percent and 8 percent of the state's population, respectively. AIDS cases in minority populations are most frequently associated with male homosexual behavior, 54 percent of cases among African-Americans and 50 percent

among Hispanics. Drug use plays a significant role in the transmission of infection among these populations, accounting for 26 percent of cases among African-Americans and 27 percent of cases among Hispanics compared with 10 percent of all cases.

The more frequent association of injecting drug use with AIDS cases in the minority community contributes to a higher incidence of AIDS among minority women than among all women. Minority women account for half of the reported cases of AIDS among women. Among minority women, 75 percent of the cases are associated with intravenous drug use either by the woman or her sexual partner. Among white women with AIDS, 65 percent of the cases are associated with drug use. This overrepresentation of minorities among women with AIDS contributes to a higher incidence of pediatric AIDS in the minority community.

The HIV epidemic significantly impacts our health care delivery system. On any given day, 10 percent of diagnosed persons with AIDS require hospitalization for acute care, and another 10 percent require extended care in a skilled nursing facility. The Chicago Department of Health estimates 20 percent of persons living with AIDS (PLWAs) lack adequate housing. Based on a study the Department completed in 1986, the average cost for PLWA hospital care from diagnosis to death in Illinois is approximately $65,000. During fiscal year 1991, the Illinois Department of Public Aid (IDPA) spent $12.3 million on inpatient care and $19.9 million for Medicaid reimbursable services for PLWAs.

There is no cure or vaccine for AIDS and the full-blown syndrome is invariably fatal. The Food and Drug Administration (FDA) has approved one drug, Zidovudine (AZT; trade name Retrovir), as a treatment for HIV infection. The Public Health Service recommends that HIV infected individuals receive prophylactic treatment early during the course of infection. The treatment recommended is AZT to inhibit progression of the disease and chemoprophylaxis against *Pneumocystis carinii* pneumonia (PCP), the most common opportunistic infection associated with HIV infection. This combination of therapies has been shown to delay the onset of illness and prolong the life of infected individuals. In fiscal year 1991, the Department spent $1.5 million in state and federal funds to provide AZT to non-Medicaid eligible, low income persons. The American Public Health Association estimates the cost of early intervention as $500 to $1,400 per year per HIV infected individual, exclusive of AZT treatment.

Despite treatment advances, prevention remains the most effective tool to control this infection. Prevention is most effectively accomplished through education on appropriate behavioral changes. To teach prevention and to allay unwarranted fears among the general and adolescent populations, racial and ethnic minority populations and persons most at risk of HIV infection, public health agencies must prepare and distribute information and materials that are culturally sensitive and age-specific.

Program Activities

General Overview

The AIDS program is administered by the AIDS Activity Section of the Division of Infectious Diseases within the Office of Health Protection. The program consists of several components: education, counseling and testing, epidemiologic surveillance and seroprevalence studies and direct services. Information on the activities in these component programs follows.

Education—Section staff continually develop and purchase educational materials for use statewide. They provide education in AIDS prevention through broad-based educational efforts and the mass media. Specialized programs are targeted to persons whose behavior places them at risk of HIV infection. These include multimedia campaigns that target adolescents, sexually active adults, women of childbearing age and men who have sex with men. To allay unwarranted fears of the public, these materials discuss HIV transmission and ways that persons can protect themselves against infection.

In addition, the Alliance of Services for AIDS Prevention (ASAP) provides programs to support behavioral change among men who have sex with men and to encourage them to learn their antibody status. The Illinois State Board of Education (ISBE) helps the Department provide teacher training workshops in AIDS education to school nurses, teachers and local health department (LHD) personnel. Finally, the Department partially funds the University of Illinois at Chicago's AIDS Outreach Intervention Project to provide prevention education to addicts not in treatment.

Counseling and Testing—Healthy People 2000 calls for 50 percent of family planning clinics, maternal and child health clinics, sexually transmitted disease (STD) clinics, tuberculosis clinics, drug treatment centers and primary care clinics to offer HIV counseling and testing services on site. Toward this end, the Department integrates confidential HIV counseling and testing services into all publicly funded STD clinics. In high prevalence areas, the program integrates the services with publicly supported tuberculosis clinics and services provided at women's health facilities. Counseling and testing services are also offered at five substance abuse clinics. The provision of HIV counseling and testing services in a variety of health care settings will help achieve the *Healthy People 2000* objective to increase to at least 80 percent the proportion of HIV-infected people who have been tested for HIV infection.

The program provides counseling and HIV antibody testing services to anyone seeking them. It targets these services for persons whose behavior places them at risk of HIV infection. These services include individual risk assessment, counseling and referrals for testing to at-risk clients of family planning clinics in areas with high HIV morbidity. But these services are increasingly used by persons concerned about their antibody status who are not at significant risk. The Department had originally planned expansion of these sites to include all LHDs. But experience and the number of blood tests positive for HIV antibodies in certain regions indicate that expanding the capacity of a few sites will better serve those most in need. This approach keeps services accessible throughout the state while keeping costs down.

Epidemiologic Surveillance and Seroprevalence Studies—Staff developed methods to evaluate the level of AIDS case reporting. They conduct complete epidemiologic investigations of all reported cases of AIDS in Illinois to determine the route of transmission and to monitor the spread of infection. They also conduct studies, consistent with federal surveillance program objectives, to estimate the seroprevalence of HIV among certain populations: STD clinic clients, IDUs entering treatment, childbearing women, adolescent males entering the correctional system, homeless persons in Chicago and women seeking abortions at two facilities (Table 2). These studies provide important data regarding the extent of the epidemic in Illinois. They also evaluate the effectiveness of various programs in curbing the spread of the infection. Staff repeat these studies each year to identify the annual rate of seroconversion (the change in an individual's test result from negative to positive, indicating the development of antibodies in response to infection).

Table 2

AIDS/HIV

HIV Seroprevalence for Selected Populations Illinois

Duration of Surveillance	Population Studied	Total (Approximate)	Percent Prevalence
1/88–9/89	Marriage license applicants	287,672	0.02
10/85–12/92	Military recruits	153,435	0.11
1/89–12/92	Volunteer blood donors	1,447,897	0.02
	Blinded seroprevalence surveys:		
8/92–10/92	childbearing women	45,709	0.14
1/92–12/92	correctional facilities—new entrants	3,157	2.57
1/92–12/92	drug treatment center clients	664	17.92
2/92–3/92	drug treatment entrants (non-injecting drug users)	483	3.73
1/92–12/92	family planning and prenatal clinic clients	2,966	0.13
1/92–12/92	homeless persons (Chicago)	390	9.23
1/92–12/92	STD clinic clients	4,912	0.67
1/92–12/92	TB clinic clients	387	0.00

Direct Services—Direct Services includes three federally funded initiatives: local HIV Care Consortia, the AIDS Drug Reimbursement Program and the Continuation of Health Insurance Coverage Program. HIV Care Consortia are operational in the seven areas of the state with the highest reported morbidity due to AIDS and HIV: Champaign, Cook, Kane, Madison-St. Clair, Peoria, Sangamon and Winnebago Counties. These consortia provide a coordinated community-based continuum of care for HIV-infected persons that includes medical and social services. The AIDS Drug Reimbursement Program provides AZT and other therapies to low income, non-Medicaid eligible persons with HIV disease. The Continuation of Health Insurance Coverage Program pays health insurance premiums for low income insured persons with HIV in danger of losing their health insurance coverage.

The Department serves as the lead agency for the Interagency AIDS Task Force, a panel that focuses on the health care and psychosocial service needs of persons with HIV-related disease. The Task Force coordinates the delivery of appropriate existing state services and the development of necessary services not currently available. It examines the role of nongovernmental, community agencies in the provision of these services and the need for fiscal resources to support these services.

Program Data

Table 3

AIDS/HIV

Target Population, Recipients and Activity Measures

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
TARGET POPULATION[1]						
Illinois residents	11,431	11,544	11,552	11,560	11,569	11,857
RECIPIENTS						
Persons receiving counseling and testing services	14,566	25,849	52,062	60,000	60,000	80,000
Reported cases of AIDS[2]	1,341	1,597	1,952	1,800	1,933	2,431
Reported cases of HIV infection (by test date)	2,236	2,720	2,492	2,385	2,504	3,196
Persons enrolled in the AIDS Drug Reimbursement Program (ADRP)	947	1,827	2,481	3,100	3,900	8,000
ACTIVITY MEASURES						
Seroprevalence surveys completed[3]	6	6	8	8	8	6
Surveys of knowledge, attitudes and beliefs completed	3	2	2	3	2	4
Persons with history of risk behavior using counseling and testing sites	6,436	8,933	19,254	25,000	25,000	35,000
Number of prescriptions filled through ADRP	625	900	850	950	1,100	2,200
Statewide information campaigns	3	3	2	1	1	10
Education pamphlets distributed[4]	800	765	1,342	1,425	1,500	1,500

1. Count in thousands. The target population for educational programs is the population of Illinois; the target population for counseling and testing services and risk reduction programs are persons engaging in behavior that places them at risk of HIV infection and is estimated at 850,000.
2. By year diagnosed.
3. Does not include studies completed independently by the Chicago Department of Health.
4. Count in thousands.

Update on 1990–1991 Process Objectives

The AIDS program listed 10 process objectives in the 1990–1991 Human Services Plan that were to be completed by fiscal year 1993. The program accomplished five objectives, partially accomplished three objectives and did not accomplish two objectives. A description follows.

Accomplished Objectives—The AIDS program accomplished the following objectives: 1) continue seroprevalence studies of five populations and begin studies of two new populations; 2) continue HIV antibody counseling and testing in TB clinics and provide individualized risk reduction counseling and referrals for HIV testing in family planning clinics, consistent with the *Healthy People 2000* objective (Increase to at least 50 percent the proportion of family planning clinics, maternal and child health clinics, sexually transmitted disease clinics, tuberculosis clinics drug treatment centers and primary care clinics that screen, diagnose, treat, counsel and provide (or refer for) partner notification services for HIV infection and bacterial sexually transmitted diseases [gonorrhea, syphilis and chlamydia]); 3) in cooperation with ISBE, continue training workshops in AIDS Readiness Programs for school nurses, teachers and local LHD personnel consistent with the *Healthy People 2000* objective (Increase to 95 percent the proportion of schools that provide age-appropriate HIV education curricula for students in 4th through 12th grade); 4) conduct multimedia public information campaigns targeting adolescents and women of childbearing age and 5) develop and circulate guidelines concerning the prevention of perinatal transmission of HIV.

Partially Accomplished Objectives—One of these objectives was to conduct knowledge, attitude and behavior surveys among the general population, homosexually active men and clients at the counseling and testing sites, STD clinics and family planning clinics. Staff stopped these surveys in October 1991 due to changing priorities at the federal level and a decrease in federal support for this particular activity. The program continues to collect specific behavioral data for persons with a history of IV drug use or male homosexual contact.

A second partially accomplished objective was to conduct a public information campaign encouraging persons at risk of HIV infection to seek testing. (This was consistent with the *Healthy People 2000* objective of increasing to 80 percent the proportion of HIV infected people who have been tested for HIV infection). The ASAP coalition conducted a campaign encouraging men who have sex with men to learn their antibody status. All other media campaigns encouraged the target audience to seek HIV counseling and testing services. The level of achievement is estimated at 20 percent.

The third partially accomplished objective was to develop and implement comprehensive health care services for persons with HIV disease in at least five geographic areas through cooperation with other appropriate state agencies and local consortia of health care providers. Federal budgetary constraints limited the development of comprehensive health care services for persons with HIV disease to four (80 percent of objective) geographic areas.

Objectives Not Accomplished—One of these was to conduct a public information campaign to publicize the AIDS hotline and AIDS prevention messages. Staff developed the materials and will conduct the campaign in fiscal year 1994.

The other objective was to implement a program to provide diagnostic and early intervention services to persons infected with HIV. In calendar year 1993 federal funding for HIV prevention programs in Illinois, including early intervention programs, has decreased 7 percent. Program staff are reviewing the effect of this reduction on the state's ability to provide diagnostic and early intervention services to persons infected with HIV.

Program Effectiveness

General

The primary outcome objective for the AIDS Activity Section is to prevent an increase in HIV seroprevalence. This is the ultimate measure of the program's effectiveness. Since little data are available concerning HIV seroprevalence among the population at large, baseline seroprevalence and annual seroconversion rates are measured in selected populations to indicate trends in these populations. Comparison of the observed seroprevalence rates from year to year permits analysis of the program's effectiveness.

Surveys of HIV-related knowledge, attitudes and behaviors provide an easier and quicker measure of the prevention program's effectiveness. Decreases in high-risk behaviors and increases in preventive behaviors will result in a decreased frequency of viral transmission and eventually in decreased morbidity due to HIV

disease. Department staff conduct surveys to determine the awareness and attitude towards AIDS among adults in Illinois. The surveys show virtually all respondents understand the ways HIV is transmitted. Recent surveys also show significant increases in the percent of respondents who report appropriate behavioral changes to protect themselves from infection.

There is indirect evidence that the Department's programs of general and targeted education and voluntary counseling and testing are slowing the spread of infection. In the early years of the epidemic, the number of diagnosed cases doubled every 12 months, but recent data show the number now doubles every 21 months. This lengthening of the doubling time has been observed despite the addition of a large number of individuals whose condition previously was not included in the CDC surveillance case definition.

Table 4

AIDS/HIV

Outcome Objectives and Actual Performance

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
Reduce number of AIDS cases						
outcome objective	1,500	1,100	1,100	1,600	1,450	1,000
actual performance	1,245	1,379	1,347	NA	NA	NA
Seroprevalence rate[1] of:						
injecting drug users						
outcome objective	13.0	16.0	18.0	20.0	25.0	30.0
actual performance	18.2	16.8	15.3	NA	NA	NA
persons seen at sexually transmitted disease clinics						
outcome objective	1.1	1.1	1.1	1.5	2.1	3.0
actual performance	1.0	0.9	0.7	NA	NA	NA
persons seen at tuberculosis clinics[2]						
outcome objective	3.2	2.1	2.8	3.5	4.0	4.0
actual performance	2.6	0.4	0.2	NA	NA	NA
persons seen at family planning and prenatal clinics[2]						
outcome objective	2.0	2.0	1.0	1.0	0.5	1.0
actual performance	0.1	0.1	0.2	NA	NA	NA
childbearing women						
outcome objective	0.1	0.1	0.1	0.1	0.1	0.1
actual performance	0.1	0.1	NA	NA	NA	NA
Rate of persons at risk who self-report remaining celibate[1]						
outcome objective	19	28	30	48	50	50
actual performance	18	NA	NA	NA	NA	NA
Rate of persons at risk who self-report using condoms[1]						
outcome objective	46	44	23	33	50	50
actual performance	34	12.5	NA	NA	NA	NA
Coordinated delivery systems in place						
outcome objective	2	8	4	4	5	8
actual performance	0	0	4	NA	NA	NA

1. Percent.
2. Data for City of Chicago are unavailable.

Assurances

Interagency Cooperation

The Department participates on an interagency council established to improve communications, coordination of services and education. The council meets quarterly. The other members are IDPA, Illinois Department of Alcohol and Substance Abuse, Department of Corrections, Department of Children and Family Services and ISBE.

Family Impact

The Department's HIV control program reduces the financial, psychological and emotional strain on persons with AIDS and their loved ones through provision of cost-effective services for persons with clinical manifestations of HIV infection. These control efforts and support services also reduce the stress of families having to deal with the disease.

Recommended Changes to Program

Current data support the need for additional efforts to prevent HIV infection among women and prevent perinatal transmission of the virus from infected women to their children. In addition to developing educational and outreach programs targeting women, especially minority women, the AIDS Activity Section will work to ensure HIV counseling and testing is routinely offered to women of childbearing age in all health care settings and in early prenatal care.

The program, in a cooperative effort with other state and local agencies, will develop additional local consortia of health care providers to plan and implement coordinated systems of medical and social services to persons with HIV disease. It will establish five local prevention coalitions and will initiate a special minority education project in Chicago. The section will continue its efforts to encourage persons at risk to seek voluntary counseling and testing. Mass media campaigns will be limited to promotion of the AIDS hotline where citizens can obtain additional information.

If the Department receives additional federal funds, the AIDS Activity Section will develop programs to determine the level of immune impairment in seropositive individuals. It will supply AZT, early chemoprophylaxis against PCP and other treatments to low-income, non-Medicaid eligible individuals.

The Department will seek guidance from the AIDS Advisory Council during the first half of fiscal year 1994 on reporting HIV cases by name to permit the Department to provide early intervention services and referrals to all seropositive individuals.

Legal Citations

AIDS Confidentiality Act, 410 ILCS 305/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 7301 *et seq.*)

AIDS Registry Act, 410 ILCS 310/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 7351 *et seq.*)

Civil Administrative Code of Illinois, 20 ILCS 2310/55.41, 55.52, 55.55, 55.56 (Ill. Rev. Stat. 1991, ch. 127, ¶ 55.41, 55.52, 55.55, 55.56)

Communicable Disease Prevention Act, 410 ILCS 315/0.01 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 22.10 *et seq.*)

Department of Public Health Act, 20 ILCS 2305/1.1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 21.1 *et seq.*)

Illinois Sexually Transmissible Disease Control Act, 410 ILCS 325/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 7401 *et seq.*)

Unified Code of Corrections, 730 ILCS 5/5-5-3 (Ill. Rev. Stat. 1991, ch. 38, ¶ 1005-5-3)

Program Title: **Infectious Diseases**

Goal

To reduce the spread of reportable infectious diseases and subsequent morbidity and mortality.

Needs Assessment

The Infectious Diseases program conducts surveillance and implements control activities for reportable infectious diseases. State regulations require physicians, other health care providers and others to report certain diseases to local health departments (LHDs). Generally, reportable diseases meet two criteria: the cause is due to a specific disease-producing agent and there is a public health intervention for prevention of other cases. Exceptions exist to this generalization.

According to the national Centers for Disease Control and Prevention (CDC), the number of infectious disease cases is tremendously underreported due to patient-related or physician-related circumstances. For example, individuals who may have a reportable disease may not seek medical care or, if they do, they may be diagnosed as having a nonreportable condition or disease. Physicians may fail to notify LHDs of individuals having a reportable disease because they may not know that the disease is reportable, believe that it was already reported, are too busy with other paperwork or are concerned that reporting such cases violates physician-patient confidentiality. The CDC estimates that approximately 2.2 million cases of infectious disease occur annually in Illinois.

During 1989, the Department began electronic reporting of communicable disease cases to CDC, accomplishing one of the national health objectives for 1990 in *Promoting Health/Preventing Disease: Objectives for the Nation.* This new reporting method provides more timely national notification of the reported incidence of communicable diseases and also allows each case to be reported in greater detail.

The Department received reports of more than 137,000 cases of infectious disease in 1990; 115,000 in 1991 and 118,000 in 1992. The Department estimates 117,000 cases will be reported in 1993 and projects that 116,000 cases will be reported in 1994.

The following is more specific information regarding several areas of disease prevention and control programs in Illinois:

Immunizations—Immunization programs seek to control vaccine-preventable diseases, including polio, diphtheria, tetanus, pertussis, measles, mumps, rubella, hepatitis B and *Hemophilus influenzae.* If children do not receive protection against these diseases through vaccination at an early age, costly hospitalization, lost school time and possible disability or death may result. Many older adolescents and adults become ill from vaccine-preventable diseases. Immunity to some diseases such as tetanus and diphtheria, provided by child immunization, requires periodic boosters. Persons who have eluded both vaccine-induced and natural immunity against measles, rubella, mumps or polio may be at increased risk for such diseases and their complications.

Each year about 180,000 infants are born in Illinois. Approximately 98 percent of all infants begin the routine immunization series; however, 30 percent do not complete the series until they enter school. Approximately 1,300,000 Illinois children aged 0 to 5 years currently need at least one immunization. Past efforts have reduced the number of totally unprotected school children aged 5 to 14 years to 125,000, or 8 percent. Public health officials need to focus on the preschool population to ensure that those children receive immunizations at the earliest medically indicated age. The 1979 and 1989 outbreaks of measles in the Chicago area show the need to increase efforts to reach minority populations.

Examples of legislative and administrative efforts to immunize all Illinois children are the legislation, rules, regulations and subsequent changes adopted in response to the 1979 and 1989 outbreaks of measles. The School Code and Department rules and regulations require children entering fifth grade for the first time to show documentation of immunizations (two doses of measles vaccine, with the first dose administered after their first birthday and the second dose administered at least one month after the first or documentation submitted by a physician that the child had measles). Students entering the 9th grade are subject to the same rules and regulations. Beginning with the 1993–1994 school year children attending schools in all grade levels will be subject to these same rules and regulations.

The College Student Immunization Act and current Department rules and regulations require students born after December 31, 1956, who attend Illinois colleges or universities for the first time or transfer from another college or university, to show proof of receipt of immunizations (including two doses of measles vaccine or evidence from a physician of past measles disease). Community colleges are exempt from these requirements and proposed legislation would also exclude any student who does not reside in a dormitory of the college or university. These two exceptions do not conform to the recommendation of the U.S. Public Health Service Advisory Committee on Immunization Practices to immunize all college and university populations.

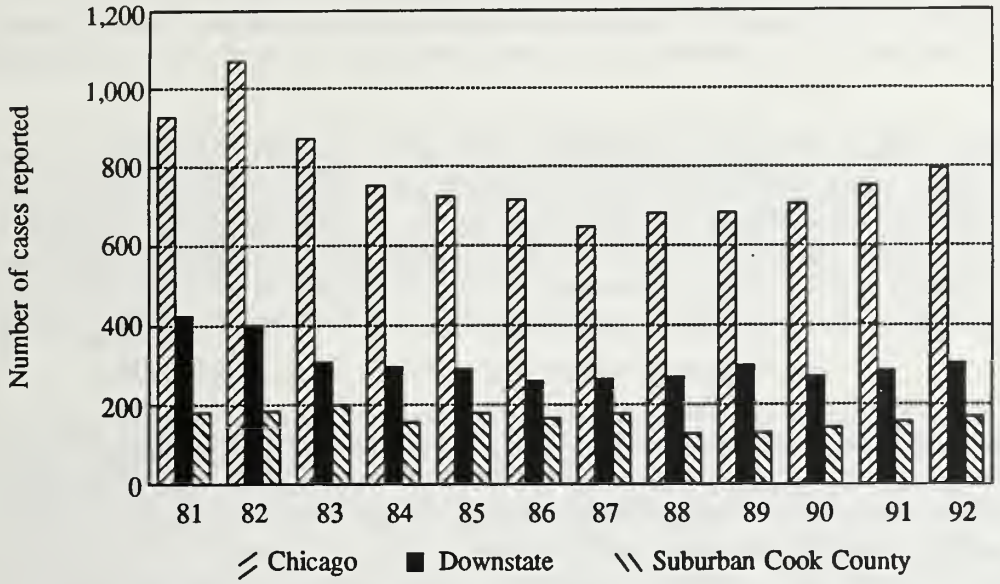
Tuberculosis—After many years of decreasing incidence, tuberculosis (TB) cases are increasing in Illinois (Figure 1). During 1991, the incidence of TB increased 7 percent (1,118 to 1,192) compared with 1990. In 1992, the incidence of TB increased 6.5 percent (1,192 to 1,270) compared with 1991. This increase, which parallels a national increase, appears to be closely correlated to the human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) epidemic. Of further concern is the potential for multiple-drug resistant tuberculosis (MDRTB). Significant outbreaks of MDRTB have occurred on the East Coast of the U.S., primarily in New York and Florida. These outbreaks, which occurred in HIV infected individuals, resulted in a 70 percent to 90 percent mortality rate. Thus far, significant MDRTB outbreaks have not occurred in Illinois, although some sporadic, relatively isolated cases have been reported.

Syphilis—The incidence of congenital syphilis in Illinois increased from nine cases in 1987 to 396 cases in 1992 (Figure 2). Several factors contribute to this increase. First, the incidence of primary and secondary syphilis among females of childbearing age increased 218 percent, from 349 cases in 1989 to 1,109 cases in 1991. Second, many pregnant women infected with syphilis do not receive timely prenatal care. Infections are not detected nor treated and there is no chance to prevent the transfer of the infection to the fetus. Third, beginning in 1989, sexually transmitted disease (STD) programs in Illinois adopted the revised CDC congenital syphilis case definition. The new case definition designates all infants born to untreated infected mothers as congenital cases regardless of their symptom status at the time of maternal treatment. This definition more accurately reflects the true incidence of congenital syphilis.

The increase in primary and secondary syphilis in Illinois during the past several years (Figure 2) has been predominantly among heterosexuals, especially those in the minority populations. During 1991, minorities accounted for 95 percent of 2,446 reported cases of primary and secondary syphilis. The trend of increasing incidence of primary and secondary syphilis in Illinois minority populations began in 1988 and is similar to a national trend that began in 1986.

Figure 1

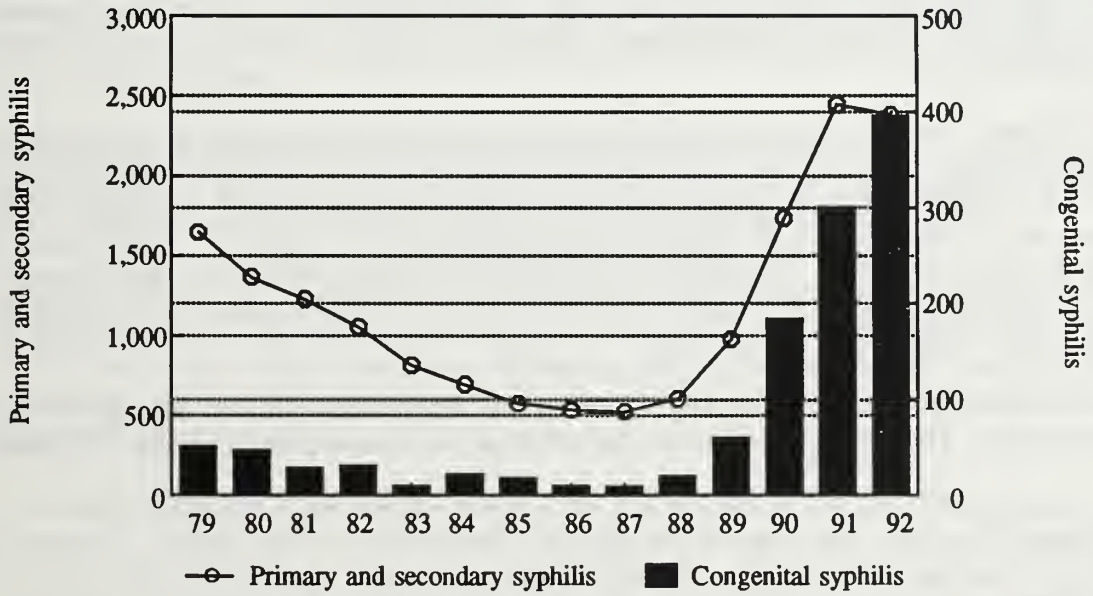
Reported Incidence of Tuberculosis
Illinois: 1981–1992



Source: IDPH, Division of Infectious Diseases

Figure 2

Primary, Secondary and Congenital Syphilis
Illinois: 1979–1992



Source: IDPH, Division of Infectious Diseases

The increase in the syphilis incidence in Illinois and the nation appears to be related to the diversion of STD resources to the HIV epidemic and the proliferation of crack cocaine use in urban communities. The use of crack cocaine contributes to the spread of syphilis among users for several reasons. Crack cocaine users have a higher incidence of exchanging sex for drugs and money. They may not know the identity of their sex partners or do not want to cooperate with a government agency because of their involvement in an illegal activity, thereby reducing sex partner notification. Since their concern about personal health generally deteriorates as drug use continues, infected persons may not seek prompt medical care when they become symptomatic.

Hepatitis B—Although the incidence of hepatitis B declined between 1976 and 1991, this disease remains a problem due to the possible severe health outcome of chronic infection with hepatitis B virus. Acute hepatitis B produces the chronic carrier state in 6 percent to 10 percent of adults and up to 90 percent of infants. One-fourth of the chronic carriers develop chronic liver disease, such as primary hepatocellular cancer and cirrhosis, the majority of whom will die prematurely from liver disease. In 1990, the Department received federal categorical grants for the testing of pregnant women and vaccination of infants born to carrier mothers.

Salmonella enteritidis—In 1988, Department staff investigated an outbreak of *Salmonella* serotype *enteritidis* and found eggs to be contaminated with the bacteria. Because the interior of eggs was previously believed to be free of pathogenic organisms, refrigeration of eggs was not required. Eggs could be held at 60 degrees Fahrenheit (F), but this action was to preserve freshness, not wholesomeness. As a result of the discovery of *Salmonella* in Illinois eggs, the Department issued emergency rules, effective September 2, 1988, requiring refrigeration of eggs at 45 F while they are under the Department's jurisdiction, i.e., in retail food stores and food service establishments. Eggs in the wholesale market, exempt from public health control, can still be held at 60 F, a temperature that allows multiplication of *Salmonella* organisms.

In 1990 an egg-associated outbreak in Illinois affected more than 1,100 persons, more than 300 persons were culture positive for *Salmonella enteritidis*. The egg farm that was the source of the eggs was found to be heavily infected. As a result, eggs from most of the 1.2 million chicken flock were removed from the commercial shell egg market. This was the largest egg-associated *Salmonella enteritidis* outbreak reported in the United States.

During 1992, *Salmonella enteritidis* continued to be a significant health problem in Illinois, accounting for 22.9 percent of the 1,585 *Salmonella* isolates recovered in the Department's laboratories. *Salmonella enteritidis* accounted for only 9.7 percent of all *Salmonella* isolates recovered in the Department's laboratories from 1986 through 1988.

Meningococcal disease—The age distribution of meningococcal cases has been steadily shifting since 1989. In 1989, 49 percent of the cases occurred in children less than 5 years of age and 8 percent occurred in children who were 10 years to 19 years of age. In 1992, 30 percent of cases occurred in children less than five years of age and 30 percent of cases occurred in children who were 10 years to 19 years of age. The reason for this change is not known. An outbreak of meningococcal disease occurred on the University of Illinois at Urbana-Champaign during 1991 and 1992 that triggered a mass vaccination program for students. Approximately 20,000 students received vaccine.

Public health officials must continue to be vigilant in the detection, treatment and prevention of communicable diseases. The target population for the Infectious Disease program is all Illinois residents.

Program Activities

General Overview

The Infectious Diseases program is administered by the Division of Infectious Diseases within the Office of Health Protection. This program consists of five sections: the AIDS Activity Section, the Communicable

Diseases Section, the Immunization Section, the Sexually Transmitted Diseases Section and the Tuberculosis Control Section. Program staff do the following: solicit and receive case reports from physicians, hospitals, school nurses and other health care workers; tabulate cases by disease, geographical location, date of onset of symptoms, age, sex, race and Hispanic ethnicity; analyze reports to determine trends that may indicate the need for alteration of local prevention strategies and investigate cases to determine any association with other cases (both reported and unreported), which might reflect a common source or ongoing exposure in the community.

The program also receives inquiries (usually by telephone, requiring immediate response) from physicians, hospital personnel, public health personnel and paramedical personnel on the diagnosis, treatment and prevention of infectious diseases. Consultation provided to these individuals takes into account recent medical research, general preventive practices and information about epidemiologic patterns that have been observed locally, nationally and internationally.

Specific Programs

Further information describing activities that are program specific follows:

Immunizations—The immunization status of children attending public and private schools and child care centers and nursery schools is assessed annually. Those children who have not received all the required immunizations complete the immunizations or are excluded from school. Parents of inadequately immunized children are encouraged to get the needed immunizations at physicians' offices, LHDs or community and school clinics. The Department purchases and distributes vaccines throughout the state to LHDs and health care providers serving public aid patients. Where health departments do not exist, the Department ships vaccines directly to other health care providers for administration in public clinics only. All providers receiving vaccines must certify that no charges will be made for the vaccine and must account for each dose received. The program uses a computerized vaccine accountability system that includes data on providers, counties and age of persons immunized. Staff continue to improve this system.

The College Student Immunization Act, effective July 1, 1989, requires all newly enrolled students in public and private colleges and universities (except students in community colleges) to present proof of immunity to measles, mumps, rubella, diphtheria and tetanus prior to class attendance. The statute also requires each institution to submit a status report within eight weeks after commencement of classroom instruction outlining its compliance status (number of students both in and out of compliance). The Department conducts individual health record reviews for compliance purposes. The total college and university enrollment in the state is approximately 692,000.

TB—The Tuberculosis Control Section staff emphasize the need for: follow-up of reported cases; critical review of local screening programs; early contact investigation and management and direct administration of medicine for patients who do not readily comply with prescribed treatment regimens.

STDs—As time and personnel permit, and with special emphasis on the control of STDs, staff conduct ongoing programs to: involve physicians actively in disease control; encourage the use of correct diagnostic procedures and recommend effective treatment regimens; provide STD and HIV risk reduction counseling and HIV testing for clinic clients; counsel individuals infected with STDs; and investigate persons exposed to or suspected of having an STD.

Other communicable diseases—The responsibilities of the Communicable Disease Control Section include the investigation of typhoid fever, viral hepatitis, meningococcal disease and arboviral disease. These diseases are transmitted by different modes and require different control measures that often involve other divisions within the Department. Staff supply immunoglobulin, human diploid cell rabies vaccine and antibiotics to physicians, LHDs and STD clinics for persons who cannot afford to pay for these treatments. They also give detailed technical guidance prior to release of these biological agents.

Program Data

Some recipients of service can be enumerated: persons who are reported to have infectious diseases; medical and other health care professionals and patients who receive consultation or educational services and persons, including children, who receive biologic agents provided by the Department that are administered for the prevention of disease.

Others who receive indirect but equally important benefits of the services cannot be quantified. Indirect recipients are those protected from an infectious disease because of Department program activities. For example, a Department investigation may identify infectious food handlers. Excluding them from food preparation prevents additional illness among persons eating the food.

Table 1

INFECTIOUS DISEASES

Target Populations, Recipients and Activity Measures

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
TARGET POPULATIONS[1]						
Illinois residents	11,431	11,543	11,552	11,560	11,569	11,857
Persons with diagnosis of:						
tuberculosis	1.1	1.1	1.2	1.2	1.3	1.0
gonorrhea, syphilis, chlamydia	27.9	26.4	25.3	24.6	23.5	20.0
vaccine preventable disease	2.1	1.7	1.5	1.5	1.4	1.3
other reportable diseases	106.3	86.5	90.0	90.0	90.0	90.0
RECIPIENTS[1]						
Persons receiving tuberculosis and communicable diseases consultation and education services	16.5	14.9	14.5	14.5	14.5	14.5
Persons receiving:						
vaccines	295	448[2]	570[2]	613[3]	654	818
antibiotics	30	32	36	33	31	30
immunoglobulin	2.3	1.9	2.0	2.0	2.0	2.0
ACTIVITY MEASURES[1]						
Doses of vaccine	1,062	1,100[2]	1,392[2]	1,912[3]	2,100	2,500
Persons receiving sexually transmitted disease counseling and testing services	361	379	398	390	380	350
Doses of antibiotics	31	33	39	35	33	32

1. Count in thousands.
2. Increases due to implementation of the two-dose measles vaccination requirement in fiscal year 1991 and the Influenza Demonstration Project and *Hemophilus influenzae* vaccination in fiscal years 1991 and 1992.
3. Increases anticipated due to implementation of universal hepatitis B vaccination and mandated participation in the Medicaid vaccine replacement program.

Program Effectiveness

General

Information on effectiveness is grouped by program areas.

Immunizations—The Department, the Illinois State Board of Education (ISBE), LHDs, school officials and health care providers made significant progress in reaching the school-aged population. The Department and ISBE helped revise the Illinois School Code in 1979 to strengthen the requirements for school physical examinations and immunizations. Prior to the 1981–1982 school year, protection levels were below 90 percent. Statewide immunization levels of school-aged children will exceed 97 percent in fiscal year 1993.

Now a similar effort must be directed to the preschool population to ensure that children are immunized as early in life as medically indicated. In the spring of 1992, the Department developed an Immunization Action Plan to ensure that by the year 2000 at least 90 percent Illinois children are fully immunized by their second birthday. This Infant Immunization Initiative is federally funded at approximately $2.2 million (includes CDC grants given directly to the City of Chicago). Public and private partnerships developed with other state agencies and key individuals and groups provide the way to improve access to immunizations throughout Illinois.

Department staff, local health officials and other health care providers continue efforts to reduce and eliminate the incidence of measles. The incidence of measles peaked in 1976 (3,992 cases), in 1979 (1,636 cases) and 1989 (3,213 cases) and declined to 24 cases in 1981 and 1982, 28 cases in 1991 and to 18 cases in 1992. In 1989, a major portion of the cases in DuPage and Suburban Cook Counties were nonpreventable (individuals who should not receive vaccines due to age or a medical condition). Approximately 75 percent of more than 2000 cases reported in Chicago were children less than 5 years of age; nearly 42 percent were preventable. Fourteen measles-related fatalities were reported from Cook County. More than 95 percent of measles cases reported in 1989 from outside Chicago were investigated within 48 hours.

Through a special appropriation in 1989, the Department spent $3.3 million to purchase 230,000 doses of measles vaccine for use in public clinics to help meet new immunization requirements previously described in this section. The Department received $3.2 million to $3.6 million each year since fiscal year 1989 for this purpose.

In 1984, the Department and Illinois Department of Public Aid (IDPA) established the first of several interagency agreements to purchase vaccines at government contract prices. The purpose of these agreements is to reduce the cost of vaccinating public aid recipients. These cooperative purchase agreements save IDPA approximately $500,000 to $1,900,000 each year. IDPA mandated participation in this program in fiscal year 1993. IDPA expects this mandate will increase savings by approximately 75 percent.

TB—The Tuberculosis Control Section improved tuberculosis control methods for local health agencies, hospitals and long-term care facilities through screening of health care workers and long-term care facility residents, contact follow-up and assuring that each patient completes the treatment regimen.

STDs—The STD Section has strengthened sexually transmitted disease programs in LHDs through education and documentation of results.

Other communicable diseases—During fiscal year 1992, the Communicable Disease Section staff provided extensive consultative and educational services to healthcare providers, LHDs and the general public. Immunoglobulin was provided for 2,300 hepatitis A contacts, and antibiotics were supplied to treat approximately 54,000 gonorrhea, syphilis and chlamydia patients. Staff also investigated all seven reported arboviral disease cases and 97.0 percent of the 1,471 reported cases of typhoid fever, viral hepatitis and meningococcal diseases in calendar year 1992.

Table 2

INFECTIOUS DISEASES

Outcome Objectives and Actual Performance

REDUCE INCIDENCE OF CASES:	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
Measles						
outcome objective	100	500	100	100	100	0
actual performance	1,057	25	5	NA	NA	NA
Mumps						
outcome objective	1,000	1,000	1,000	1,000	750	500
actual performance	114	138	85	NA	NA	NA
Class III tuberculosis[1]						
outcome objective	10.0	9.5	9.5	9.5	9.2	3.5
actual performance	9.6	10.3	10.9	NA	NA	NA
Gonorrhea[1]						
outcome objective	350	300	280	260	250	223
actual performance	343	296	269	NA	NA	NA
Primary and secondary syphilis[1]						
outcome objective	10	15	20	18	15	9
actual performance	15	21	23	NA	NA	NA
Primary and secondary syphilis among blacks[1]						
outcome objective	40	90	120	150	140	75
actual performance	94	133	149	NA	NA	NA
Congenital syphilis[1]						
outcome objective	30	100	150	200	225	50
actual performance	97	158	240	NA	NA	NA
Hepatitis A[1]						
outcome objective	NA	9.7	9.7	9.7	9.7	9.7
actual performance	9.7	12.3	9.0	NA	NA	NA
Hepatitis B[1]						
outcome objective	NA	7.1	7.1	7.1	7.1	7.1
actual performance	6.6	3.7	3.5	NA	NA	NA
Parenterally transmitted non-A, non-B hepatitis[1]						
outcome objective	NA	1.4	1.4	1.4	1.4	1.4
actual performance	1.1	0.9	1.0		NA	NA
Bacterial meningitis[1]						
outcome objective	4.7	4.7	4.7		4.7	4.7
actual performance	4.2	2.9	2.5		NA	NA
Typhoid fever acquired in Illinois[2]						
outcome objective	1.0	1.0	1.0	1.0	1.0	1.0
actual performance	0.6	0.03	0.1	NA	NA	NA

1. Per 100,000 population.
2. Per 1,000,000 population.

Assurances

Interagency Cooperation

All infectious disease program activities are conducted in concert with LHDs. A liaison is maintained with other state and federal agencies. The Department shares STD case records of patients younger than 11 years of age with the Department of Children and Family Services (DCFS) to assist in the detection of child abuse. It reports data to the CDC. The Department maintains liaisons with the Illinois Environmental Protection Agency, U.S. Food and Drug Administration, Illinois Department of Agriculture and U.S. Department of Agriculture. These agencies regulate industries or activities involved in outbreaks of diseases.

The development and revision of the publication "Management of Chronic Infectious Diseases in School Children" was a joint effort between the Department and ISBE. This publication provides information on several chronic infectious diseases and describes routine hygienic and sanitation practices to prevent the spread of many other infectious diseases transmitted by direct contact and contaminated environmental surfaces.

The assessment of the immunization status of school children involves a survey coordinated with ISBE. The Immunization Section staff assist the ISBE Task Force Committee in revising survey methods and questionnaire design. Both agencies provide staff to verify the survey data by spot-checking school records. The ISBE and the Department provides all regional superintendents with a report on the survey results. These reports emphasize to the superintendents their responsibility to correct those school situations in which the immunity levels of children is less than 90 percent and withhold 10 percent of state aid until immunization levels exceed 90 percent. The Immunization Section, with the concurrence of school district superintendents, provides survey results to local health care facilities and private physicians.

The Immunization Section and DCFS cooperate to assure that children meet the immunization requirements prior to entry into a day care facility. DCFS provides a list of all licensed day care centers statewide while the immunization program sends a letter to all licensed day care centers statewide with immunization survey guidelines and a questionnaire returnable to the Immunization Section. Section staff provide follow-up to nonresponding day care facilities and do data compilation. The data are reviewed by both agencies to identify the facilities that care for children who have low immunization rates. A list of such facilities is distributed to LHDs and DCFS supervisors who take corrective action.

The Early Periodic Screening Diagnosis and Treatment (EPSDT) Program of IDPA provides preventive health services, including physical examinations and immunizations, to public aid recipient children eligible for medical services. The Immunization Section supplies vaccine to EPSDT providers. The two programs, through the contractual agreement described earlier, provide vaccines to public aid recipient children. IDPA pays providers for administering vaccines and the Department provides vaccines to private physicians for public aid recipients.

Family Impact

Program efforts, including the immunization of children, control the spread of infectious diseases; reduce morbidity and mortality associated with infectious diseases; and decrease the emotional stress of illness associated with medical expenses and time lost from work.

Recommended Changes to Program

Many disease outbreaks occur in specialized institutional settings. Day care center outbreaks probably occur more often now because the number of day care centers and the number of children attending them are growing rapidly. The nursing home industry's increased recognition and concern about infectious disease

problems is reinforced by the intense scrutiny of government agencies, the press and the public. Hospital-associated infectious disease outbreaks increase costs and length of hospitalization and have been documented frequently in the past. Unnecessary transmission of infectious diseases in these facilities leads to excess hospitalizations and increased costs.

Currently, the Department can provide only limited epidemiological assistance in solving these episodes. The program technical staff needs expanded expertise to address these important problems of infectious diseases in day care centers, nursing homes and hospitals. This need is partially underscored in two of the *Healthy People 2000* objectives. One objective (20.5) seeks a 10 percent reduction in the incidence of surgical wound infections and nosocomial infections in intensive care patients. The other objective (20.8) aims to reduce by 25 percent the incidence of infectious diarrhea in children attending licensed child care centers.

Many hospitals experiencing financial stress are reducing support to various internal functions, including hospital infection control programs, forcing infection control nurses to seek more outside technical assistance than in the past. The Department is the appropriate and logical reference source for this information and these services. This cooperation with hospital infection control nurses, the cornerstones of the infectious disease reporting system, will also improve disease control.

Legal Citations

Child Care Act of 1969, 225 ILCS 10/7 (Ill. Rev. Stat. 1991, ch. 23, ¶ 2217)

Civil Administrative Code of Illinois, 20 ILCS 2310/55.13 (Ill. Rev. Stat. 1991, ch. 127, ¶ 55.13)

Civil Administrative Code of Illinois, 20 ILCS 2310/55.65 (Ill. Rev. Stat. 1991, ch. 127, ¶ 55.61)

College Student Immunization Act, 110 ILCS 20/0.01 *et seq.* (Ill. Rev. Stat. 1991, ch. 144, ¶ 2600 *et seq.*)

Communicable Disease Report Act, 745 ILCS 45/0.01 *et seq.* (Ill. Rev. Stat. 1991, ch. 126, ¶ 20 *et seq.*)

Department of Public Health Act, 20 ILCS 2305/1.1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 21.1 *et seq.*)

Illinois Sexually Transmissible Disease Control Act, 410 ILCS 325/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 7401 *et seq.*)

Infant Eye Disease Act, 410 ILCS 285/0.01) *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 4700 *et seq.*)

Prenatal Syphilis Act, 410 ILCS 320/0.01 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 4800 *et seq.*)

Reye's Syndrome Reporting Act, 410 ILCS 245/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 5701 *et seq.*)

School Code, Health examiniations and immunizations, 105 ILCS 5/27-8.1 (Ill. Rev. Stat. 1991, ch. 122, ¶ 27-8.1)

Unified Code of Corrections, 730 ILCS 5/5-5-3 (Ill. Rev. Stat. 1991, ch. 38, ¶ 1005-5-3)

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Program Title: **Environmental Health**

Goal

To reduce the incidence of disease and injury related to environmental factors.

Needs Assessment

The role of environmental health programs has expanded in recent years to reduce or eliminate the incidence of disease associated with exposure to environmental factors and injury associated with the use of structures. Such structure-related injuries include diving accidents in public swimming pools, recreational equipment hazards in licensed youth camps and electrocution hazards in modular dwellings and other facilities regulated by the Department.

All the nearly 11.6 million persons living in Illinois will use or benefit from an environmental health program. Program services protect health and safety by assuring worker competence in structural pest control, water well construction, water well pump installation, private sewage disposal and lead-paint and asbestos abatement. Inhabitants of migrant labor camps and mobile home parks and people who use campgrounds, swimming pools and bathing beaches are also program recipients. The environmental health laws and regulations establish standards for the operation of these facilities.

Through enforcement of environmental health codes, the incidence of historical waterborne diseases has been eliminated or tremendously reduced. Maladies of the 19th century and early 20th century such as typhoid fever and dysentery, which killed thousands of people, are generally unheard of today. New illnesses such as giardiasis and legionellosis have taken their toll and require renewed application of environmental engineering processes and public health principles for control. Although public water supplies and sewage systems are closely monitored, more than 25 percent of the state's population use private sewage disposal systems and almost 10 percent receive their water from sources other than municipal or public water supplies.

In recent years the general public and public health personnel voiced increased concern about the adverse health effects associated with exposure to asbestos, very low levels of chemical and radiological contaminants, hazardous waste sites, lead and vector-borne diseases. Specifics follow.

Asbestos—Chronic obstructive lung diseases such as asbestosis, mesothelioma and lung cancer are linked to asbestos exposure. From 1985 through 1987, 240 new cases of mesothelioma were reported in Illinois. Mesothelioma has a latency period of 20 to 30 years and it is estimated that six of these new cases were exposed as children. Most of the 2 million school children and 212,000 school staff in Illinois' 6,300 schools may be exposed to asbestos.

Chemical and Radiologic Contaminants—Exposure to various chemical or radiological agents in the home, workplace and environment is associated with both acute and chronic health effects (i.e., cancer, birth defects, liver and kidney disease, nervous system damage, lung problems, etc.). Illinois is a major agricultural and industrial state. Its residents are exposed to pesticides; solvents; polychlorinated biphenyls (PCBs); dioxins; lead; mercury; arsenic; radon and other potentially hazardous materials or conditions through air, water, soil and food.

Hazardous Wastes Sites—The general public and health professionals have special concerns about the health risks to the thousands of people living near the 500 hazardous waste sites listed by the Illinois Environmental Protection Agency (IEPA) or near the 2,000 other known hazardous waste sites in Illinois. Health care professional must address the dangers of environmental contaminants, indoor air pollution and other environmental factors near these sites.

Lead—Childhood lead poisoning is the nation's leading preventable childhood environmental illness. Lead poisoning has affected 3 million children younger than 6 years of age in the U.S., with minority and low-income communities disproportionately affected. In 1993, Department staff expect to screen 300,000 children for lead poisoning and identify approximately 36,000 (12 percent) who will have blood lead levels that indicate lead poisoning.

Lead poisoning is especially insidious in children less than 7 years of age. Lead causes permanent neurologic damage at blood levels lower than previously thought, leading to learning disabilities, impaired hearing, reduced attention span and behavioral problems.

Lead poisoning can occur from exposure to plumbing products, batteries, petroleum products and other articles containing lead. However, the most common source of a child's exposure to excessive lead is the enormous quantity of chipping and peeling lead paint found in older homes. About 4 million homes in the U.S. have chipping and peeling lead-based paint and children younger than age 7 years living there. Homes built before 1978 contain more than 3 million tons of lead in painting alone.

Vector-Borne Diseases—Lyme disease is transmitted by a spirochete carried by the deer tick. The first case of Lyme diseases occurred in 1985. The Department recorded 219 cases from 1987 to 1992. If not diagnosed and treated, Lyme disease causes serious problems with the heart, nervous system and joints. But Lyme disease can be difficult to diagnose. About 30 percent of the cases are diagnosed in the later stages when it is more difficult to treat.

After several years of little activity, California encephalitis cases increased in northwest Illinois. Encephalitis is a virus transmitted from small mammals to humans by the bite of certain mosquitoes. It causes an irritation of the lining of the brain. Symptoms include fever, headache, nausea, vomiting and stiffness of the neck. It is more common in children under 15 years of age. Only three cases occurred between 1986 and 1991, but 15 confirmed cases occurred in 1991 and seven occurred in 1992. Warm, wet springs bolster the mosquito population, contributing to the increase in this disease. Investigations of the residences of the persons with encephalitis found water-filled containers in which disease-carrying mosquitoes can breed.

After several years of little activity, Illinois also saw a large increase in mosquito-borne Saint Louis encephalitis (SLE) activity in wild birds. The disease is transmitted from the birds to humans by the bite of certain mosquitoes. As a type of early-warning system, Department staff collect wild birds to test their blood for the SLE virus. Finding the virus in birds warns of a potential outbreak of the disease in humans. In 1992, twelve birds collected in southern Illinois tested SLE-positive.

Program Activities

General Overview

The Environmental Health program is administered by the Division of Environmental Health within the Office of Health Protection. The program consists of a broad spectrum of environmental health components. Program activities include inspections, investigations, plan reviews, issuance of construction permits, vocational testing and licensing and facility licensing and sampling (Table 1). The Department conducts investigations to decide the validity of complaints in all areas of environmental health. Staff also conduct special investigations to respond to emergencies or immediate health hazards. Enforcement of adopted regulations becomes necessary when an inspection or complaint investigation reveals that a facility or licensee does not meet the regulations. Generally, non-compliance causes a potential health or safety hazard for persons who use licensed facilities or for persons who rely on licensed individuals for services regulated by this program. Department staff use the administrative hearing process and the offices of the state's attorneys and attorney general to pursue compliance.

A description of program activities in specific areas follows.

Air, Soil, Water and Food—Staff review and interpret the results of soil, air, water and food analyses to assess the health effect to those exposed. They determine the extent of the hazard, the necessity for medical or other intervention and the need for more study.

Table 1

ENVIRONMENTAL HEALTH

Activities by Program Component

	Inspections	Construction Permits	Vocational Licenses	Facility Licenses
PROGRAM COMPONENTS				
Asbestos abatement	X		X	
Environmental toxicology	X			
Field sanitation	X			
Lead abatement	X		X	
Migrant labor	X	X		X
Mobile home parks	X	X		X
Non-community water systems	X	X		
Private sewage	X	X	X	
Private water	X	X	X	
Structural pest control	X		X	X
Swimming pools and bathing beaches	X	X		X
Vector control	X			
Youth camp and campgrounds	X	X		X

Program staff investigate reports of geographic clustering of cancer and other diseases to learn whether there is any possible environmental item associated with the cluster. They deal with indoor air pollution, industrial hygiene and fish consumption advisories. They also provide education on health hazards associated with exposure to hazardous chemicals in the environment. Staff distribute medical bulletins, citizen pamphlets and workshop and audiovisual materials to health care professionals and the public. Based on health assessments or identified problems, the program targets areas of the state to increase local health care professionals' awareness of health concerns that may be related to environmental factors.

Asbestos—Staff monitor public and private school asbestos abatement projects and license the inspectors, management planners, project designers, project managers, workers, supervisors and air sampling professionals to help ensure competent action and reduce the health threat of asbestos. Licensed asbestos inspectors identify the types, location and extent of asbestos to determine the appropriate corrective action to manage or abate the asbestos hazard. Staff review plans prepared by the management planners and conduct on-site audits to evaluate the appropriateness of the recommended actions.

Facility Construction—The program issues permits for the construction of campgrounds, migrant labor camps, mobile home parks, swimming pools and bathing beaches and youth camps. Staff also publish guidelines on public spa and whirlpool design and operation. They review plans and specifications and issue a license if the facility or equipment is in compliance with the law and codes governing the construction activities. These facilities must maintain a license to continue their operations.

To determine whether facilities can renew their licenses, program staff inspect the facilities each year to determine compliance with the applicable law and code. A facility found in substantial compliance with the code is eligible for license renewal the following year. The program refuses to license or revokes the current license of a facility that threatens public health.

Hazardous Waste Sites—The program conducts assessments of health risk to populations living near approximately 500 hazardous waste sites or industrial facilities known to IEPA. The United States Environmental Protection Agency (USEPA) lists 40 of these facilities and sites on the National Priority List as the most hazardous in the nation, releasing potentially harmful materials into the environment.

Lead Abatement and Control—Program staff conduct environmental lead inspections to identify the source of exposure for lead poisoning exposure. If the source of lead is a dwelling occupied by the child, the owner must abate the lead hazard.

Public Water Systems—Program staff periodically inspect and sample all non-community public water systems for bacteriological and chemical contaminants. They also inspect private and semi-private water systems after receiving a complaint.

Structural Pest Control—Program staff periodically inspect structural pest control companies and conduct field inspections with certified technicians or individuals under their supervision. The purpose of these activities is to educate applicators about the selection, mixing and use of pesticides; eliminate or reduce the incidence of illness and property damage; and ensure that the rules and regulations are followed. The program licenses and registers pest control companies annually and renews vocational licenses for technicians every three years. Individuals who seek certification in structural pest control must meet educational standards and pass a test. They must attend Department approved training programs before certification renewal.

Vector Control—Staff conduct surveys for mosquitos and other vectors and make vector control recommendations to local health officials. They collect and test birds for St. Louis encephalitis. They investigate the locale where cases of mosquito-borne California encephalitis (LaCrosse sub-type) occur, looking for artificial containers—such as discarded tires—that mosquitos may use as a breeding ground. Staff also identify geographic areas where Lyme-infected deer ticks are found, recommend measures to reduce the threat or severity of infection and identify specimens of ticks submitted by the public or physicians.

Program staff administer grants to local health departments (LHDs) to develop vector control activities that eliminate or reduce human disease and discomfort caused by insects, spiders, ticks, rats, mice, birds and other animals that can carry disease-producing organisms to humans. In fiscal years 1991 and 1992, 21 and 19 local agencies received vector control grants, respectively.

Water Wells and Private Sewage Disposal—Staff license, inspect and issue permits for the work of persons who construct or install water wells, water well pumps and private sewage disposal systems and wells. Individuals must meet a combination of education and experience requirements before taking an examination. If they pass the examination, they receive vocational licenses. Failure to do all work according to applicable laws and codes can cause license suspension or revocation.

The division supports LHD involvement in most of these activities and the LHDs are doing much of that work. In addition, Department staff review and interpret water sample results for homeowners and administrators of regulated facilities.

Program Data

Table 2

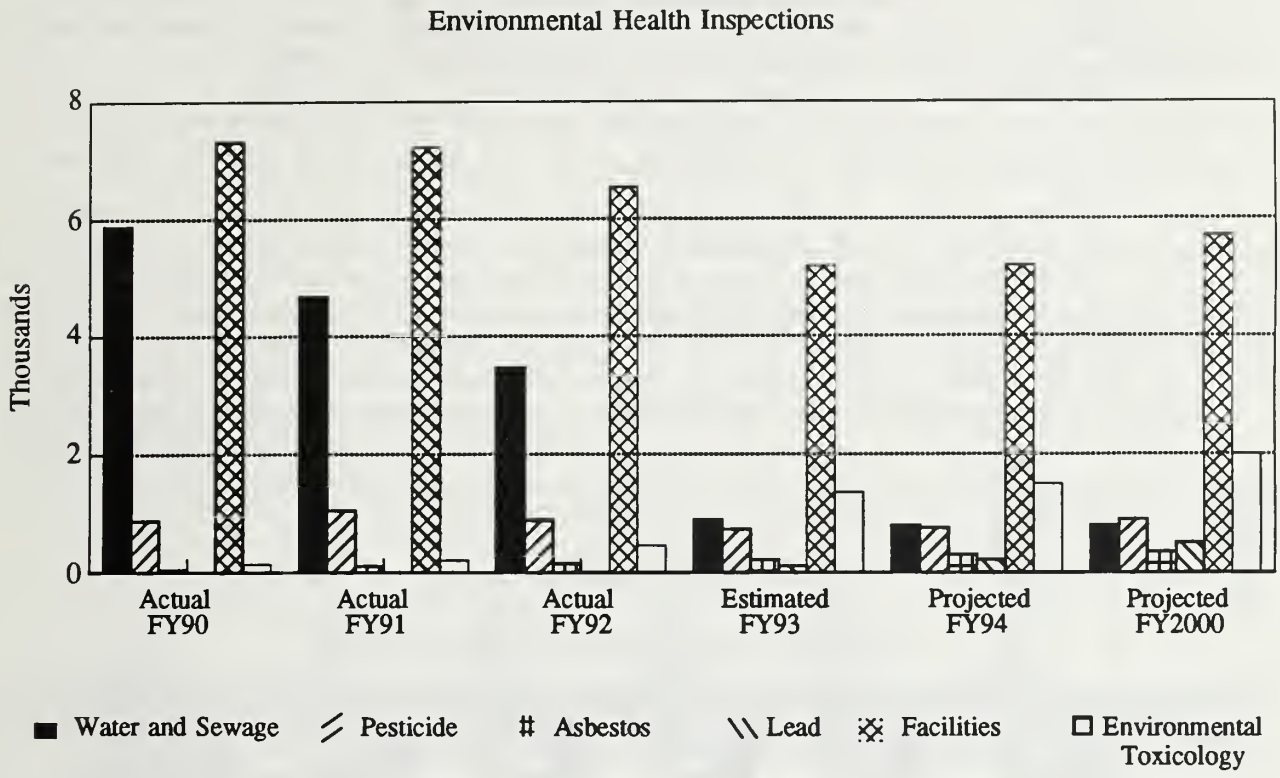
ENVIRONMENTAL HEALTH

Target Population and Activity Measures

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
TARGET POPULATION[1]	11,431	11,543	11,552	11,560	11,569	11,857
ACTIVITY MEASURES						
Inspections	14,237	13,226	11,507	8,480	8,700	10,200
Construction permits	6,924	2,484	1,858	1,650	900	800
Vocational licenses	23,990	14,014	13,843	14,130	14,700	19,700[2]
Facility licenses	6,120	5,850	6,081	6,110	6,200	6,500
Total activities	51,271	35,574	33,289	30,370	30,500	37,200

1. Count in thousands.
2. Currently, only supervisors (technicians) of persons who apply pesticides must be licensed. An expected amendment to the Illinois Structural Pesticide Act will require that those who apply the pesticides must be licensed.

Figure 1



Source: IDPH, Division of Environmental Health

Large cuts in the state budget during fiscal year 1992 affected the division's activities in the environmental health program. Budget cuts resulted in staff reductions in Chicago and Springfield; reduced travel funds; and the elimination of: water and sewage inspections in counties without LHDs, operational and complaint investigations in mobile home parks, mobile home tie-down approvals, inspections of manufactured housing and bird control training (Figure 1).

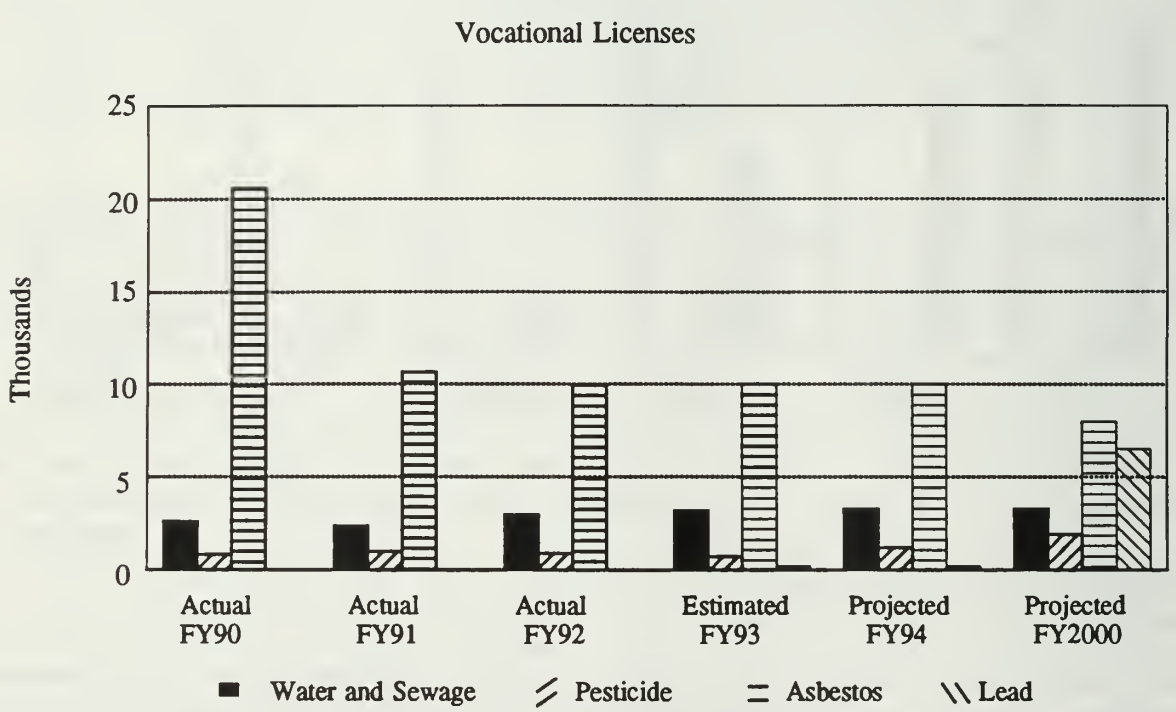
The transfer of some environmental health program activities to LHDs also reduced the projected level of activity in the program, e.g., the city of Chicago assumed the inspection of swimming pools and bathing beaches within its jurisdiction.

Reduced inspection estimates for fiscal year 1993 reflect the impact of budget cuts and the Project Health initiative, which recommended that LHDs become responsible for some environmental health services. LHDs will take over water supply and sewage disposal system inspections as recommended by Project Health, further reducing the number of inspections conducted (Figure 1). Although the number of water and miscellaneous facility inspections are being reduced, the increase in environmental toxicology inspections and the addition of the lead abatement inspections will increase total inspections by the year 2000 back to pre-fiscal year 1992 levels.

The issuance of construction permits will continue to decline through the year 2000 (Table 2). Because of staff reductions due to budget decreases, the division expects to issue fewer construction permits for manufactured housing. The number of construction permits issued by the Department for non-community water supplies, wells, pools and beaches will decrease as local authorities take over these functions. There should be no change, however, in the number of construction permits issued to youth camps, campgrounds, migrant labor camps and mobile home parks.

The drop in the number of vocational licenses during fiscal years 1991 and 1992 was due to a change in handling asbestos from encouraging abatement to managing it in place, which reduced the demand for licensed asbestos workers. But the number of vocational licenses issued will return to fiscal year 1991 levels by fiscal year 2000 due to: the licensing of lead abatement inspectors beginning in fiscal year 1993 and lead abatement contractors and workers beginning in fiscal year 1994; and the expected change in pesticide laws that will expand licensing to include all persons involved in pesticide applications (Figure 2).

Figure 2



Source: IDPH, Division of Environmental Health

Facility licenses for youth camps, campgrounds, mobile home parks, migrant labor camps, swimming pools and bathing beaches will continue to increase at a low rate (Table 2). But the increase may level off or decrease if, under the Project Health initiative, LHDs begin to license these facilities.

Process Objectives

- By 1993, begin sampling non-transient, non-community public water supplies for 44 various chemicals, including lead and copper, to determine compliance with maximum contaminant levels established by USEPA under the federal Safe Drinking Water Program
- By 1994, revise the Asbestos Abatement Act and Code to be consistent with federal regulations
- By 1994, develop regulations creating fines and penalties for infractions of the Structural Pest Control Act and Code
- By 1994, develop and distribute guidelines for Integrated Pest Management in schools and distribute to the more than 1000 school districts
- By 2000, increase the involvement of LHDs in the vector control, pesticide and the water and sewage program components as part of Project Health

Program Effectiveness

An increase in the percentage of water sample results that meet the standards for drinking water systems reduces the likelihood of disease associated with drinking water systems. Only one waterborne disease outbreak has occurred in Illinois in the last five years. Program staff expanded the water program component in fiscal year 1991 to include previously unregulated non-community public water supplies. This increased the percentage of contaminated samples found and, therefore, changed some annual outcome objectives (Table 3). But, the Department still expects to reach its fiscal year 2000 objective to limit the number of contaminated water samples to less than 5 percent of non-community water supply samples collected.

A new objective shown in Table 3 is to reduce the incidence of pesticide misuse by individuals employed with licensed pest control companies to no more than 50 by fiscal year 2000. Program staff expect to reduce the number of pesticides misused through interaction with the newly created Structural Pest Control Advisory Council. The council is a diverse board created to advise the Department on regulations and examinations and assist in the preparation of guidelines regarding Integrated Pest Management in schools. The council should encourage enhanced training efforts by industry and other pesticide seminar sponsors to reduce pesticide misuse trends. Meanwhile, the Department continues to perform inspections of pest control companies and their employees' use of pesticides.

Table 3

ENVIRONMENTAL HEALTH

Outcome Objectives and Actual Performance

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
Non-community public water system water samples not in compliance[1]						
outcome objective	+0.50[2]	8	12	10	8	5
actual performance	–2.62[2]	11	12	NA	NA	NA
Number of pesticide misuse incidents by licensed companies[3]						
outcome objective	NA	NA	NA	68	66	50
actual performance	NA	NA	70	NA	NA	NA

1. Percent.
2. The outcome objective was changed in FY91 from "percent of facilities with violative samples" to "percent of all violative samples.
3. This in a new objective for FY93.

Assurances

Interagency Cooperation

Many environmental health program activities require close coordination and cooperation with other state agencies. Due to the diverse nature of the program, the Department frequently receives requests for assistance and consultation in areas such as water and sewage treatment, pest control, indoor air pollution, occupational diseases, lead abatement and health hazard evaluations.

Several program components, including non-community water systems, environmental toxicology, groundwater protection and private sewage disposal systems, require close cooperation with IEPA. The Department and IEPA share a federal grant that the Department uses for the non-community water component of the program.

Division staff represent the Department on the Small Community Wastewater Treatment Committee of the Governor's Rural Affairs Council. Other state agencies represented on this council are IEPA, the Department of Commerce and Community Affairs and the Illinois Community Action Association and the Illinois Rural

Groundwater Association. Division staff also take an active part on the Groundwater Sub-committee of the Illinois Coordinating Committee on Groundwater. Representatives of the Illinois State Water Survey, the State Geological Survey, the Department of Energy and Natural Resources, the Department of Mines and Minerals, the State Fire Marshal, IEPA and the Illinois Farm Bureau also serve on this committee.

The program's review of hazardous waste site records for initial health assessments is a cooperative effort with IEPA, which keeps these records. Additionally, these assessments require the Department to interact with the Illinois Departments of Conservation, Agriculture, Nuclear Safety, Labor and several federal agencies. The program also works together with the University of Illinois School of Public Health to investigate environmental and occupational health hazards.

The Department is involved with the Department of Agriculture in several cooperative efforts. In behalf of the Department, the division participates in a federal grant that funds structural pest control regulatory activities authorized by the Federal Insecticide, Fungicide and Rodenticide Act. Division staff participates on the Interagency Committee on Pesticides, which is chaired by the Department of Agriculture. Also, the Department of Agriculture is a participant on the Department's new Structural Pest Control Advisory Council.

Vector control personnel work with LHDs, IEPA and mosquito abatement districts (20 county-based units that focus on eliminating the insects and their breeding places) to monitor accumulations of discarded tires that are frequented by insects carrying disease-producing organisms. Personnel also work with LHDs to monitor bird populations for St. Louis encephalitis, to investigate the association of mosquito-borne California encephalitis with artificial containers such as discarded tires and to conduct surveys for ticks.

The asbestos abatement component of the program requires a cooperative effort of the Department, the Illinois State Board of Education (ISBE), IEPA and the Capital Development Board for construction-related activity in public schools. The Department advises ISBE of updates in the state and federal asbestos abatement programs, coordinates inspection activities with IEPA and informs the Capital Development Board of needed corrective action.

Program staff represent the Department on the Inter-Agency Committee on Migrant Affairs along with the departments of Rehabilitation Services, Children and Family Services, Employment Security, Public Aid and Board of Education. They also represent the Department as participants on the Illinois Housing Development Authority.

Family Impact
By reducing the incidence of personal disease and injury related to environmental factors, the environmental health program has improved the health status of Illinois residents, relieving families of the emotional and financial burden of these illnesses and indirectly contributing to family stability.

Recommended Changes to Program

The Project Health initiative will transfer the responsibility for many environmental health services from the Department to LHDs. The Environmental Health program will provide support to the LHDs, which will be held accountable for such direct services as inspections and construction reviews and approvals. Program staff will set standards, provide technical advice and secure financing for the LHDs.

The division is expanding its lead paint assessment and abatement program to provide consultation on the elimination of lead hazards, conduct 70 environmental lead inspections in fiscal year 1993 and require dwelling owners to abate any lead hazards found. In 1993 the Department began to license lead inspectors, expecting to license 200 inspectors by 1994. By 1994, the Department will initiate the licensing of lead abatement contractors and workers to prevent the hazards caused by lead-based paint and its mitigation.

During fiscal year 1993, the division proposed regulations to establish fines and penalties under the Structural Pest Control Act. These regulations will be created with the assistance of the newly created 10-member Structural Pest Control Advisory Council.

The Illinois Groundwater Protection Act mandates that the Department issue permits for all private and non-community drinking water system wells, inspect all non-community water systems and collect samples for the analysis of 44 chemicals, including lead and copper, as required by USEPA regulations. In fiscal years 1988 and 1989 the Department tested 700 samples for the presence of 8 chemicals. In fiscal year 1993 this testing program will include testing for all 44 chemicals. In 1994, water may have to be tested for the presence of 67 chemicals and water may have to be tested for 111 different compounds by 1997.

In 1994 the Asbestos Abatement Act was amended to coincide with federal regulations and permit the Department to impose administrative fines and file civil suits against violators.

Legal Citations

Asbestos Abatement Act, 105 ILCS 105/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 122, ¶ 1401 *et seq.*)

Asbestos Hazard Emergency Response Act, 15 USC 2441 *et seq.*

Campground Licensing and Recreational Area Act, 210 ILCS 95/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 761 *et seq.*)

Department of Public Health Act, 20 ILCS 2305/1.1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 21.1 *et seq.*)

Environmental Toxicology Act, 415 ILCS 75/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 981 *et seq.*)

Federal Insecticide, Fungicide and Rodenticide Act, 7 USC 136 *et seq.*

Field Sanitation Act, 210 ILCS 105/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 5901 *et seq.*)

Illinois Groundwater Protection Act, 415 ILCS 55/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 7451 *et seq.*)

Illinois Manufactured Housing and Mobile Home Safety Act, 430 ILCS 115/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 67½, ¶ 501 *et seq.*)

Illinois Migrant Labor Camp Law, 210 ILCS 110/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 185.1 *et seq.*)

Illinois Water Well Construction Code, 415 ILCS 30/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 116.111 *et seq.*)

Illinois Water Well Pump Installation Code, 415 ILCS 35/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 116.151 *et seq.*)

Lead Poisoning Prevention Act, 410 ILCS 45/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 1301 *et seq.*)

Mobile Home Park Act, 210 ILCS 115/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 711 *et seq.*)

Private Sewage Disposal Licensing Act, 225 ILCS 225/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 116.301 *et seq.*)

Public Nuisances Act, 740 ILCS 55/221 *et seq.* (Ill. Rev. Stat. 1991, ch. 100½, ¶ 26 *et seq.*)

Safe Drinking Water Act, 42 USC 300f *et seq.*

Structural Pest Control Act, 225 ILCS 235/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 2201 *et seq.*)

Swimming Pool and Bathing Beach Act, 210 ILCS 125/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 1201 *et seq.*)

Vector Control Act, 410 ILCS 95/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 7801 *et seq.*)

Water Well and Pump Installation Contractor's License Act, 225 ILCS 345/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111, ¶ 7101 *et seq.*)

Youth Camp Act, 210 ILCS 100/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 549 *et seq.*)

Program Title: **Consumer Product Protection**

Goal

To prevent contamination and disease transmittal through foods, drugs, medical devices and cosmetics.

Needs Assessment

A nutritious, wholesome food supply is one of the most significant factors influencing people's health. Unsafe or contaminated food may result in sickness, hospitalization or even death. Milk surpasses most other foods as a single source of dietary elements needed to maintain proper health, especially in children and older citizens. However, milk has a high potential to serve as a carrier of disease and it has been associated with serious human disease outbreaks. Manufacturers of drugs, medical devices and cosmetic products market many new products each year. These products may endanger the health, safety and well-being of consumers if improperly designed or manufactured. Many pharmaceutical companies market new generic drugs to compete with the more expensive brand name drugs. However, most prescribers and consumers are not able to determine if a generic drug is equivalent to its more expensive brand name counterpart.

Public health agencies establish consumer product protection programs to maintain and promote the health and well-being of consumers. These programs focus on products of the food, dairy, pharmaceutical and medical device industries. The purpose of these programs is to promote safe production, distribution and use of products of these industries and to prevent false and misleading labeling of such products.

Federal, state and local public health officials in Illinois share responsibility for regulating the food industry. The regulatory approach that provides the greatest degree of assurance for food safety is one that uses hazard analysis critical control point (HACCP) strategies. The elements of HACCP are: assessment of hazards associated with producing, processing, transporting, storing and preparing foods; determination of critical control points necessary to control identified hazards; and the establishment of procedures to monitor the critical control points.

The Department, in conjunction with the U.S. Food and Drug Administration (USFDA), continuously provided HACCP training for local health department (LHDs) and state agency personnel that regulate retail food operations. The objective: to have all inspectors trained to render the same interpretation and evaluation of a site's adherence to the food code (i.e., "standardization"). Due to budget reductions in 1992 and 1993 the Department discontinued these training and program evaluation efforts with state and local agencies.

Federal and state legislation continue to impose new mandates on the Department. Most federal mandates depend on state and local government funding. Examples include the Nutrition Labeling and Education Act (NLEA), FDA Model Food Code, Seafood HACCP Program and Shellfish Certification. When federal funds are provided they are inadequate. For example, the annual USFDA contracts for the inspection of 375 food processing plants do not reflect the increasing costs to the Department to conduct the inspections.

An exception to the nonfunded or inadequately funded mandate is the recently passed Tanning Facility Permit Act authorizing Department oversight of the rapidly growing industry, effective July 1, 1992. This act requires all facilities that irradiate the human body for cosmetic or nonmedical purposes to obtain a permit to operate from the Department. Based on discussions with states of similar size, the Department estimates that it will receive at least 2,000 applications for permits. During fiscal year 1993, 1,354 establishments applied for a permit. Unlike many mandates, this act established the Tanning Facility Permit Fund for the deposit of the permit fees to be used for the purpose of conducting activities related to tanning facilities.

While consumer protection programs continue to monitor the food, drug, dairy and cosmetic industries, reductions in federal and state budgets that fund such programs threaten their future effectiveness. The Consumer Product Protection program must find innovative ways to meet current and new federal and state mandates with reduced staff and funds. The target population is all Illinois residents.

Program Activities

General Overview

The Consumer Product Protection program is administered by the Division of Food, Drugs and Dairies within the Office of Health Protection. Besides direct service through the inspection of processed food, dairy and tanning establishments, the program supports LHDs that regulate retail food service establishments and food stores by promulgating statewide retail food rules, issuing interpretations, training and assisting LHDS in other matters. The division maintains an Incident Reporting System. Information on foodborne illness investigations, transportation wrecks, fires and other environmental hazards to food safety is collected and maintained in a computer database.

The following information describes activities by specific program areas:

Certificate of Free Sale—Illinois manufacturers of foods, drugs and medical devices and cosmetic products require a Certificate of Free Sale, to export Illinois products to certain foreign countries. The Department issues this document upon request to certify that the items noted are manufactured in Illinois and are freely available in Illinois and other states in the United States; the manufacturer is subject to the requirements of the Illinois Food, Drug and Cosmetic Act; and there is no legal action pending for violations (as of the current date).

Drug Product Selection—This program area provides prescribers and pharmacists with information needed to prescribe and dispense an approved, generically equivalent drug product at lower cost when such action is acceptable to the consumer and not prohibited by the physician. The program is based on an extensive list of more than 4,200 individual drug products covering 470 separate drugs or combinations of drugs.

To help administer this program, the Department has a seven-member Technical Advisory Council appointed by the Department with the governor's concurrence. The council consists of two practicing pharmacists, two pharmacologists, two physicians and one "other" prescriber. The "other" prescriber may be a physician, a podiatrist, a dentist or an osteopath. Candidates are selected from the recommendations of the Illinois Pharmacists Association, the Illinois State Medical Society, the Illinois Podiatric Medical Association and the Illinois Osteopathic Physicians and Surgeons Association.

The council reviews all products before recommending their inclusion in the Illinois Formulary for the Drug Product Selection Program. Drugs are screened for compliance with promulgated criteria and listed after assurance that they are safe, effective and bioequivalent. Drug products selected for interchange must come from among those generically equivalent products approved and listed in the current edition of the formulary.

This program distributes copies of the formulary and interim updates to pharmacies, pharmacists and physicians in the state and other interested parties nationwide. It provides consumers with significant savings on prescription drug expenses and assures health practitioners that interchange occurs only with bioequivalent drugs.

Food—The food program encompasses several elements. One of these elements is to respond to emergency situations involving illness or injury in certain retail food establishments. The specific food establishments are those located in areas of the state not covered by LHDs, which provide direct services such as inspections and complaint investigations. Another element is the certification of food service management personnel in food service sanitation skills. Also, the program is responsible for inspecting and collecting samples at food processing warehouse and salvage establishments. The food program carries out the required enforcement activity and contracts with LHDs for inspections of the USDA subsidized Summer Food Program for children feeding sites.

The division has a pilot program with four LHDs to evaluate the feasibility of new risk-based performance standards for LHD retail food programs. These standards were developed as part of the Illinois Public Health Improvement Project. Their format with outcome and process objectives is based on the Model Standards: A Guide for Community Preventive Health Services and incorporate the pertinent objectives of *Healthy People 2000* whenever possible. The division provides consultative services to all the LHDs on the use of the new food program standards.

Food Service Manager Certification—Program staff train food service managers to become proficient in safe food service operations. Food service managers receive instruction in food protection, cause and prevention of foodborne disease, facility construction, personal hygiene, food handling practices, food codes and laws, training techniques and management practices. These individuals must then demonstrate their competency by successfully completing an examination which tests the areas in which they received training. Each year the fee system of $35 for a new or renewed five-year certificate and $10 for a replacement certificate generates approximately $750,000, which is deposited in the General Revenue Fund. But due to budget restrictions, Food Service Manager Certification testing has been reduced to one location per month in each of the Department's regions.

Milk—To improve the quality of milk available, staff conduct sanitation inspections of milk producing farms and processing plants, evaluate the adequacy of milk and milk product pasteurization equipment, inspect tank truck cleaning and sanitizing facilities and license bulk milk tank operators. Staff conduct plant inspections of manufacturers of single-service food containers (disposable cups, cottage cheese containers, plastic spoons, etc.) to determine acceptability of their products for use by Grade A dairy plants. Strict enforcement of the laws prevents milk and dairy products from becoming contaminated and causing diseases. Effective enforcement allows Illinois-produced milk to move in interstate commerce.

In 1991, the National Conference of Interstate Milk Shippers amended the Pasteurized Milk Ordinance to require the testing of all raw milk shipments for drug residues. In 1993, those changes were promulgated into Illinois rules. The division oversees the testing of all raw milk, the subsequent disposal of contaminated loads and assures the enforcement of penalties against those producers responsible for the adulteration. The division requires that producers be educated to stress drug residue prevention.

The Department began a training and standardization program to assure that all dairy farm inspectors are able to properly interpret, document and enforce all dairy laws and requirements. This successful program emphasizes uniformity to new and existing staff.

Table 1

CONSUMER PRODUCT PROTECTION

Target Population and Activity Measures

	Actual FY90	Actual FY91	Actual FY92	Actual FY93	Estimated FY94	Projected FY2000
TARGET POPULATION[1]	11,431	11,543	11,552	11,560	11,569	11,857
ACTIVITY MEASURES						
Inspections:						
food processing and warehouse	1,571	1,421	1,128	1,150	1,100	1,100
retail food establishments	1,392	853	493	0[2]	0[2]	0[2]
grade A and manufactured milk facilities	8,286	7,679	7,477	7,223	7,000	6,000
single-service container plants	30	29	30	32	35	35
drug, medical device and cosmetic manufacturers	235	160	115	0[2]	0[2]	0[2]
tanning facilities by Department staff	NA	NA	NA	150[3]	0[4]	0[4]
Local health department (LHD) program reviews	42	44	48	0[2]	20[5]	50[5]
LHD sanitarian standardizations[6]	98	48	68	0[2]	30[5]	75[5]
Department supervisor standardizations[6]	41	15	10	0[2]	10[5]	10[5]
Food service managers certified	22,558	19,275	13,641	14,232	14,000	15,000
Certificates of free sale issued	1,283	1,386	1,516	2,775	2,900	3,200
Illinois Formularies distributed	40,000	41,000	40,000	4,000	4,000	4,000
Tanning facility permits issued	NA	NA	NA	1,300	2,000	2,000

1. Count in thousands.
2. Program discontinued due to budget reductions.
3. Establishments to be inspected under FDA contract.
4. Establishments to be inspected by LHDs.
5. Consultations and reviews for new local health protection grant code requirements.
6. Training inspectors to give the same interpretation and evaluation of a site's adherence to the food code.

Program Effectiveness

An accurate count of food service facilities, food processing plants and warehouses in the state is impossible, because no permit, license or registration is required by state statute. Additionally, limited personnel resources prevent annual review of facilities. By prioritization and work planning with USFDA, the Department inspects most complex food establishments every two to five years.

In other areas related to food, the training and certification of food service managers contributed significantly to improved sanitation levels in food service establishments statewide (Table 2). The level of sanitation improved during the last two years at Summer Food Service Program meal preparation and feeding sites (see **"Interagency Cooperation," p. 86**).

The high Interstate Milk Shippers (IMS) compliance rating indicates the effectiveness of the dairy program (Table 2). The low number of violations of the rules and regulations is partially due to additional inspections and improved inspection detail. When Illinois maintains a 90 percent rating, Grade A dairy products may be shipped to national and international markets. IMS rates the sanitation compliance of all aspects of the dairy production and processing industry and rates the enforcement activities of the supervising regulatory agency. The rating results are published nationally and provide for reciprocity for sale of dairy products in all participating states or localities. Compliance by Department and the industry with IMS ratings is required for the industry's continued expansion of its Grade A markets.

Table 2

CONSUMER PRODUCT PROTECTION

Outcome Objectives and Actual Performance

	Actual FY90	Actual FY91	Actual FY92	Actual FY93	Estimated FY94	Projected FY2000
Average sanitation scores of retail food establishments[1]						
outcome objective	58.0	59.0	60.0	61.0	63.0	65.0
actual performance	57.7	58.8	NA[2]	NA[2]	NA	NA
Interstate Milk Shippers compliance rating[3]						
outcome objective	90.0	90.0	90.0	90.0	90.0	90.0
actual performance	93.5	92.0	92.3	92.8	NA	NA

1. Based on standardization inspections conducted with local health department staff.
2. Program elimination due to budgetary reductions.
3. Percent.

Assurances

Interagency Cooperation

The Consumer Product Protection program does the following interagency work:

- conducts inspections of selected food processing establishments for USFDA
- coordinates inspections of USDA's Summer Food Service for Children feeding and food preparation sites for the Illinois State Board of Education
- conducts food sanitation inspections at the Illinois and DuQuoin State Fairs for the Illinois Department of Agriculture
- monitors pesticide contamination in Illinois sportfish on behalf of the Department, a participant in an interagency effort with the Illinois Department of Conservation and the Illinois Environmental Protection Agency
- exchanges milk industry information with the Department of Agriculture, the agency responsible for monitoring dairy heard health
- coordinates information on generic drug availability with federal agencies and the Illinois Departments of Public Aid, Mental Health and Developmental Disabilities, Central Management Services and Revenue who use the drug information to secure quality generic drug products on contractual purchases or set maximum provider reimbursement limits on generically available products

Family Impact

Consumer Product Protection program promotes the health and well-being of Illinois families by its regulation of the food, drug, dairy and cosmetic industries. In addition, the money saved by Illinois families using the equivalent generic drug program can be used for other family needs.

Recommended Changes to Program

The Consumer Product Protection staff recommends several program changes, including some that require budget adjustments. The recommendations are as follows:

- require state and local food sanitation personnel to receive federal HACCP training to reduce and prevent foodborne illness
- make the recently proposed retail food standards part of the Department's rules and regulations to help reduce and eliminate situations that cause foodborne illness
- initiate an advanced food service manager training and certification program targeted for supervisory level personnel who are responsible for multiple units of a food establishment or who train other food service managers
- require state registration of food establishments to facilitate tracking of recalled food products and allow immediate contact in emergency situations
- require training and certification of dairy plant pasteurization operators to ensure proper operation of milk pasteurization equipment
- require federal training of program staff responsible for medical device inspection to maintain an effective enforcement program
- develop local public health services in counties where they do not exist to assure local effective sanitation regulation of local retail food establishments
- require licensure of bulk milk tanks to facilitate tracking in emergency situations and to ensure compliance with sanitation maintenance and operation requirements in accordance with prescribed standards

Legal Citations

Civil Administrative Code of Illinois, 20 ILCS 2310/55-55.69 (Ill. Rev. Stat. 1991, ch. 127, ¶ 55-55.69)

Counties Code, 55 ILCS 5/5-25013 (Ill. Rev. Stat. 1991, ch. 34, ¶ 5-25013)

Food Handling Regulation Enforcement Act, 410 ILCS 625/0.01 *et seq.* (Ill. Rev. Stat. 1991, ch. 56½, ¶ 330 *et seq.*)

Grade A Pasteurized Milk and Milk Products Act, 410 ILCS 635/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 56½, ¶ 2201 *et seq.*)

Hearth Baked Bread Act, 410 ILCS 640/0.01 *et seq.* (Ill. Rev. Stat. 1991, ch. 56½, ¶ 288.9 *et seq.*)

Illinois Food, Drug and Cosmetic Act, 410 ILCS 620/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 56½, ¶ 501 *et seq.*)

Pharmacy Practice Act, 225 ILCS 85/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111, ¶ 4121 *et seq.*)

Public Health District Act, 70 ILCS 905/15(5), 17(2) (Ill. Rev. Stat. 1991, ch. 111½, ¶ 15.5, 17.2)

Salvage Warehouse Store Act, 240 ILCS 30/0.1 *et seq.* (Ill. Rev. Stat. 1991, ch. 114, ¶ 400.1 *et seq.*)

Sanitary Food Preparation Act, 410 ILCS 650/0.01 *et seq.* (Ill. Rev. Stat. 1991, ch. 56½, ¶ 66.90 *et seq.*)

Tanning Facility Permit Act, 210 ILCS 145/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 8351-1 *et seq.*)

3P_E_CPP.HSP

Program Title: **Public Health Laboratory**

Goal

To support public health programs with accurate, timely environmental sample and clinical specimen examination and reporting of results.

Needs Assessment

The prevention and control of disease requires a cooperative effort at local, state and federal levels. Local health departments (LHDs), clinics, hospitals, physicians and other health care providers and officials need reference laboratory and consultation services provided by public health laboratories. Many of these services are provided at the state level. Others are done at the federal level at the facilities of the Centers of Disease Control and Prevention (CDC).

At Department facilities routine services include complex testing for infectious diseases, food and water contamination, the presence of toxic elements in the environment and the presence of alcohol or other abusive substances in drivers. Because of the complexity of the testing procedures at public health laboratories, those who submit specimens for testing must follow specific directions to ensure that the tests can be properly done and the results are not compromised. While most specimens can be submitted and tested during normal laboratory hours, sometimes emergencies occur that may require testing to be done immediately, such as testing for rabies. Then Public Health Laboratory staff receive and test such emergency specimens at night and during weekends and holidays.

The Public Health Laboratory program is experiencing significant increases in use of its resources. One example is the Centers for Disease Control and Prevention's (CDC) request to do surveillance and seroprevalence studies for the human immunodeficiency virus (HIV) infection in individuals who are suspect HIV carriers. Recent data from CDC indicate that the number of individuals in the U.S. who have been diagnosed with acquired immunodeficiency syndrome (AIDS) doubled from 100,000 to 200,000 in only two and one-tenth years. According to program figures, the ratio of the number of HIV tests done to the number of positive findings is between 20 and 30 specimens tested for every positive finding (Table 1).

Another example of the increasing demand is the recently enacted Illinois Childhood Lead Poisoning Prevention Act. This act requires children ages 6 months to 6 years to be tested for blood lead levels prior to enrollment in school. This has contributed to the increase in the number of blood lead tests: 20,123 in fiscal year 1991, 35,000 in fiscal year 1992 and an estimated 100,000 in fiscal year 1993.

A third example of the increasing demand is the newly promulgated testing requirements of the United States Environmental Protection Agency. These requirements have increased the number of complex chemical and microbiological analyses required of program staff for collected water samples, including tests to assure the absence of hazardous levels of pesticides.

Such increases in demands for public health laboratory services are usually accompanied by major increases in the expenditures for supplies, equipment, repair and service contracts on the equipment and personnel services. However, the recent early retirement program reduced staff considerably, making the fulfillment of basic laboratory services very difficult. The challenge for the program is to seek improved automation and the most competitive commodity prices to maintain or lower the cost per test. The target population is all Illinois residents.

Program Activities

General Overview

The Public Health Laboratory program is administered by the Division of Laboratories within the Office of Health Protection. The division conducts laboratory analyses for the health assessment activities administered by programs throughout the Department. The coordinated actions of this and other divisions within the Department and local health authorities minimize the overall impact of endemic or epidemic health issues in Illinois.

To serve the various needs of the Department, LHDs and other health care providers, the division maintains comprehensive testing capabilities in its clinical and environmental laboratories located in Carbondale, Chicago and Springfield. Staff do more than 220 different tests to identify the presence of bacterial, congenital, mycotic, parasitic and viral diseases and toxic substances. The virology laboratory staff test for arboviruses, influenza, enteroviruses, respiratory viruses, herpes viruses, hepatitis and retroviruses (which include the virus that causes AIDS). They also test for other sexually transmitted diseases (STDs). The environmental laboratories conduct chemical and microbiological analyses on water samples, food and dairy products.

Table 1

PUBLIC HEALTH LABORATORY

Activity Measures

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
ACTIVITY MEASURES						
Specimens tested:						
HIV antibodies	13,932	22,464	30,000	42,000	53,000	75,000
pediatric blood lead	16,236	20,123	35,000	100,000	100,500	103,000
newborns metabolic diseases	242,000	245,000	246,000	250,000	255,000	285,000
water supply samples	27,503	27,521	28,621	30,000	35,000	45,000
PERFORMANCE INDICATORS						
Positive findings:						
reactive HIV specimens	808	945	1,500	1,500	1,600	2,000
elevated blood leads	1,428	1,797	4,300	12,000	13,000	20,000
reactive metabolic specimens	200	211	270	275	280	300
nitrate or coliform found	19,350	19,264	20,034	21,000	24,500	31,500

Each year division staff receive approximately 250,000 specimens taken from newborns to test for six different congenital metabolic diseases: phenylketonuria (PKU), galactosemia, biotinidase, hypothyroidism, congenital adrenal hyperplasia and hemoglobinopathies (including sickle cell anemia). The number of specimens received is approximately 28 percent more than the number of births because of retest requirements due to discharge of infants before 24 hours of age. PKU tests are valid at 36 to 48 hours of age.

Staff use training, proficiency testing and consultation to maintain and improve the quality of clinical testing done in Illinois. The current level of quality in Department facilities meets the requirements of the 1988 Clinical Laboratory Improvement Act.

As part of its membership in the National Laboratory Training Network the division's training staff use materials developed by CDC to train staff at other laboratories. Division staff also administer the proficiency test program for laboratories participating in blood alcohol and substance testing certification.

Program Effectiveness

A review of the program's stated objectives reveals difficulty in maintaining or achieving these objectives (Table 2). The recent federal and state mandates to provide additional testing and the state's early retirement program that reduced laboratory staff contributed to the difficulty in meeting specific objectives.

To improve overall laboratory effectiveness and efficiency, the program recently installed a central computerized system to support the transmission of specimen test data from three laboratories to LHDs. This system also monitors and controls the laboratories' fiscal and budget items and updates supply inventories. Staff seek to constantly improve the system to meet new demands of the Department.

Table 2

PUBLIC HEALTH LABORATORY

Outcome Objectives and Actual Performance

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
Cost of newborn metabolic disease test($)						
outcome objective	.90	.93	2.40[1]	2.50	2.55	3.00
actual performance	.85	2.40	2.40	NA	NA	NA
Testing turnaround time[2]						
Non-AIDS specimens						
outcome objective	8	10	10	10	10	10
actual performance	8	8	8	NA	NA	NA
AIDS specimens						
outcome objective	10	10	9	7	7	7
actual performance	9	7	7	NA	NA	NA
Deviations per semi-annual inspection of Department labs						
outcome objective	3	3	3	3	6[3]	5
actual performance	3	3	2	NA	NA	NA

1. Due to increased cost for sickle cell test.
2. Number of days.
3. Due to the implementation of the 1988 Clinical Laboratory Improvement Act.

Assurances

Interagency Cooperation
The public health laboratories work closely with the Illinois Environmental Protection Agency in various water analysis. Program staff frequently do food analyses in consultation with the Illinois Department of Agriculture.

Family Impact
The laboratory program indirectly strengthens and promotes stability within Illinois families. The division's various activities in support of the Department's programs include correctly identifying an inborn error of metabolism in a newborn, quantifying the blood lead level of a child, determining the causative agent in an infection and confirming a clinical diagnosis.

Recommended Changes to Program

A laboratory cytology program will be introduced to monitor cervical cancer in maternal and child health block grant recipients.

Legal Citations

Civil Administration Code of Illinois, 20 ILCS 2310/55.09-55.11 (Ill. Rev. Stat. 1991, ch. 127, ¶ 55.09-55.11)

Clinical Laboratory Improvement Act 1988, 42 USC § 263a

Counties Code, 55 ILCS 5/3-3013 (Ill. Rev. Stat. 1991, ch. 34, ¶ 3-3013)

Department of Public Health Act, 20 ILCS 2305/1.1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 21.1 *et seq.*)

Grade A Pasteurized Milk and Milk Products Act, 410 ILCS 635/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 56½, ¶ 2201 *et seq.*)

Illinois Marriage and Dissolution of Marriage Act, 750 ILCS 5/105, 204, 206 (Ill. Rev. Stat. 1991, ch. 40, ¶ 105, 204-206)

Lead Poisoning Prevention Act, 410 ILCS 45/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 1301 *et seq.*)

Phenylketonuria Testing Act, 410 ILCS 240/0.01 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 4902.9 *et seq.*)

Problem Pregnancy Health Services and Care Act, 410 ILCS 230/1-100 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 4601 *et seq.*)

Toxicological Laboratory Service Act, 410 ILCS 60/0.01 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 200.9 *et seq.*)

3P_F_LAB.HSP

Program Title: **Plumbing**

Goal

To ensure all plumbing systems are installed properly to prevent health and safety problems to users.

Needs Assessment

Improperly installed plumbing contributes to the introduction of contaminants into potable water systems, the escape of toxic gases and explosions that could cause injury and death. The inspection of new, remodeled and existing plumbing systems helps eliminate these types of health and safety problems.

However, there is shortage of local and state plumbing inspectors throughout Illinois. Some local government entities either have no plumbing inspection activities or employ unqualified individuals. The importance of proper plumbing to public health should warrant an active, qualified plumbing program in every municipality.

The target population is all Illinois residents.

Program Activities

General Overview

The program seeks to accomplish its goal through testing, inspections and investigations. Apprentice plumbers must pass an examination that tests their competence before they receive a plumbing license from the Department. Program staff inspect new, remodeled and existing plumbing systems to eliminate health and safety hazards in water distribution systems, drainage lines, vents and plumbing fixtures. Staff investigate incidents of unlicensed individuals performing plumbing work and take enforcement measures as necessary to ensure such individuals stop this illegal activity. They also assist with the inspections of experimental plumbing systems.

Table 1

PLUMBING

Activity Measures

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
ACTIVITY MEASURES						
Inspections:						
plumbing installation	17,050	19,063	15,345	13,500	13,888	15,000
license verifications	713	409	332	350	350	350
Tests						
plumbers	6,500	6,700	7,000	6,900	6,700	6,800
apprentices	1,700	2,000	2,500	2,400	2,500	2,800

Program Effectiveness

The lack of funding for plumbing inspectors throughout Illinois prevented the program from being more efficient and effective. However, a 1992 amendment to the Illinois Plumbing License Law included two

changes that should provide increased funding for this program. One change authorized the Department to establish new schedules of fees for testing and licensing plumbers and to supply copies of the Illinois State Plumbing Code to interested persons or groups. The second change established the Plumbing Licensure and Program Fund into which all fees collected for testing, issuing licenses and copies of the code are to be deposited. This fund is dedicated to the administration and enforcement activities of the program and will provide a means for increasing the number of inspectors.

Table 2

PLUMBING

Outcome Objectives and Actual Performance

	Actual 1990	Actual 1991	Actual 1992	Estimated 1993	Projected 1994	Projected 2000
Plumbing installation inspections						
outcome objective	13,888	13,888	13,888	12,896	13,888	14,888
actual performance	17,050	19,063	15,345	NA	NA	NA
Investigation of unlicensed individuals						
outcome objective	NA	NA	NA	300	250	200
actual performance	713	409	332	NA	NA	NA

Assurances

Interagency Cooperation

The Department works closely with several state agencies. Together with the Illinois Environmental Protection Agency, it adopts, promotes and develops an active program to eliminate and prevent cross-connections (parts of plumbing installations that may allow waste water to be back-siphoned into potable water systems) throughout the state. Program staff conduct seminars and workshops to inform and test individuals' competence to properly install backflow and backsiphonage preventers. Program staff also conduct plumbing inspections for the departments of Aging, Corrections and Mental Health and Developmental Disabilities. In addition, staff inspect water heaters of the Department of Energy and Natural Resources for compliance with the American Society of Heating, Refrigerating and Air Conditioning Engineers, Inc. standard number 90.

The Department consults with the Illinois State Board of Plumbing Examiners and the Plumbing Code Advisory Council regarding examinations, license hearings, present code requirements and the need to update and develop rules and regulations to address changing technology. Program staff worked with the Capital Development Board to propose and adopt rules in the plumbing code that assist and strengthen rules and regulations for accessibility standards.

Family Impact

The program makes individuals aware of the need to protect potable water supplies and provides Illinois families citizens with quality plumbing systems by requiring that violations of the Plumbing Code be corrected.

Recommended Changes to Program

In fiscal years 1993 and 1994, the Department will continue to evaluate the safety and effectiveness of water conserving plumbing fixtures and other advances in plumbing design to assure proper health protection when such devices are used.

Legal Citations

Illinois Plumbing License Law, 225 ILCS 320/0.01 *et seq.* (Ill. Rev. Stat. 1991, ch. 111, ¶ 1100.01 *et seq.*)

3P_G_PLM.HSP

CHAPTER IV

OFFICE OF HEALTH CARE REGULATION

Introduction

Mission

To evaluate and enforce compliance with quality of care standards by long-term care facilities, hospitals, emergency service providers and other health care delivery systems.

Summary of Responsibilities

General Overview

State and federal laws require the Department to regulate certain health care facilities, equipment, programs and providers. The Office of Health Care Regulation (OHCR) evaluates each of these to determine compliance with state and federal regulations.

OHCR derives authority from two sources. First, the Department acts as the certifying agent for the federal Health Care Financing Administration (HCFA), which governs facility and program participation in Medicare and Medicaid. Second, state laws authorize the Department to develop and enforce minimum standards for the operation of health care facilities and programs, issuing licenses to facilities and programs that are in compliance. The type of facility or program determines whether federal regulations, state regulations or both apply. The Department surveys each applicant facility or program. Then it notifies HCFA if the facility or program is in compliance with Medicare regulations and notifies the Illinois Department of Public Aid (IDPA) if the facility or program is in compliance with Medicaid regulations.

Several of the laws OHCR administers establish advisory boards with members representing regulated facilities or programs, other government agencies, health care professions and consumers. These boards enhance the office's effectiveness in developing clear and concise rules that address health, safety and accountability issues by providing different perspectives and expertise than are available in the Department. Staff spend considerable time to provide support to these boards.

Methods of Carrying Out Responsibilities

The following are examples of OHCR's annual quality-of-care activities:

- inspect and survey approximately 7,000 health care delivery settings for compliance with certification and licensure requirements
- review 1,650 plans for the construction or rehabilitation of new and existing long-term care facilities, hospitals and ambulatory surgical treatment facilities
- investigate and respond to more than 4,500 complaints regarding the care provided in long-term care facilities, hospitals, home health agencies and ambulatory surgical treatment centers
- approve and monitor nurse aide training and competency programs
- investigate and respond to complaints involving emergency medical services providers
- designate trauma centers and approve trauma region plans
- test and license more than 9,600 emergency medical care technicians
- inspect more than 2,000 ambulances

- develop and promulgate administrative rules that implement new state mandates
- certify the accuracy of more than 4,000 breath test analysis instruments
- test and license more than 9,000 operators of breath test analysis machines

Priorities

OHCR has an unusual role within the Department because of its focus on regulation. Due to state legislation and federal congressional actions, regulatory activities must be carried out by specified methods within specified time limits. Examples specified by statute and regulation are the forms used and the time limits for scheduling annual inspections, complaint investigations and submission of documentation.

All programs experienced increases in workload due to changes in state and federal laws, changes in the public's expectations of health care and increases in facility and program size and number. OHCR programs met the workload increases without increases in resources. Instead, the fiscal year 1993 state budget required 21 layoffs in OHCR. The federal fiscal year 1993 HCFA budget for Medicare programs also had significant reductions. This situation threatens the office's ability to continue effective monitoring of health care facilities and programs. Thus, the priority of OHCR is to meet the increasing workloads of federal and state mandates with reduced staff levels.

Divisions

OHCR is composed of several major components. Descriptions of primary responsibilities of each follow:

The ***Budget and Fiscal Section*** is responsible for OHCR state and federal budgets, expenditures, contracts and other fiscal activities.

The ***Bureau of Long-Term Care*** consists of the Division of Long-Term Care Field Operations and the Division of Long-Term Care Quality Assurance and the Education and Training Section. The Field Operations and Quality Assurance divisions administer state and federal regulatory programs of long-term care facilities. Staff inspect, evaluate findings and initiate enforcement action. The Education and Training Section coordinates federal and state surveyor training, certifies nurse aide training programs, maintains the Nurse Aide Registry and coordinates training for surveyors, the long-term care industry and consumer groups.

The ***Division of Administrative Rules and Procedures*** develops state rules, manages the office's response to state and federal legislation and federal rulemaking and develops policies and procedures.

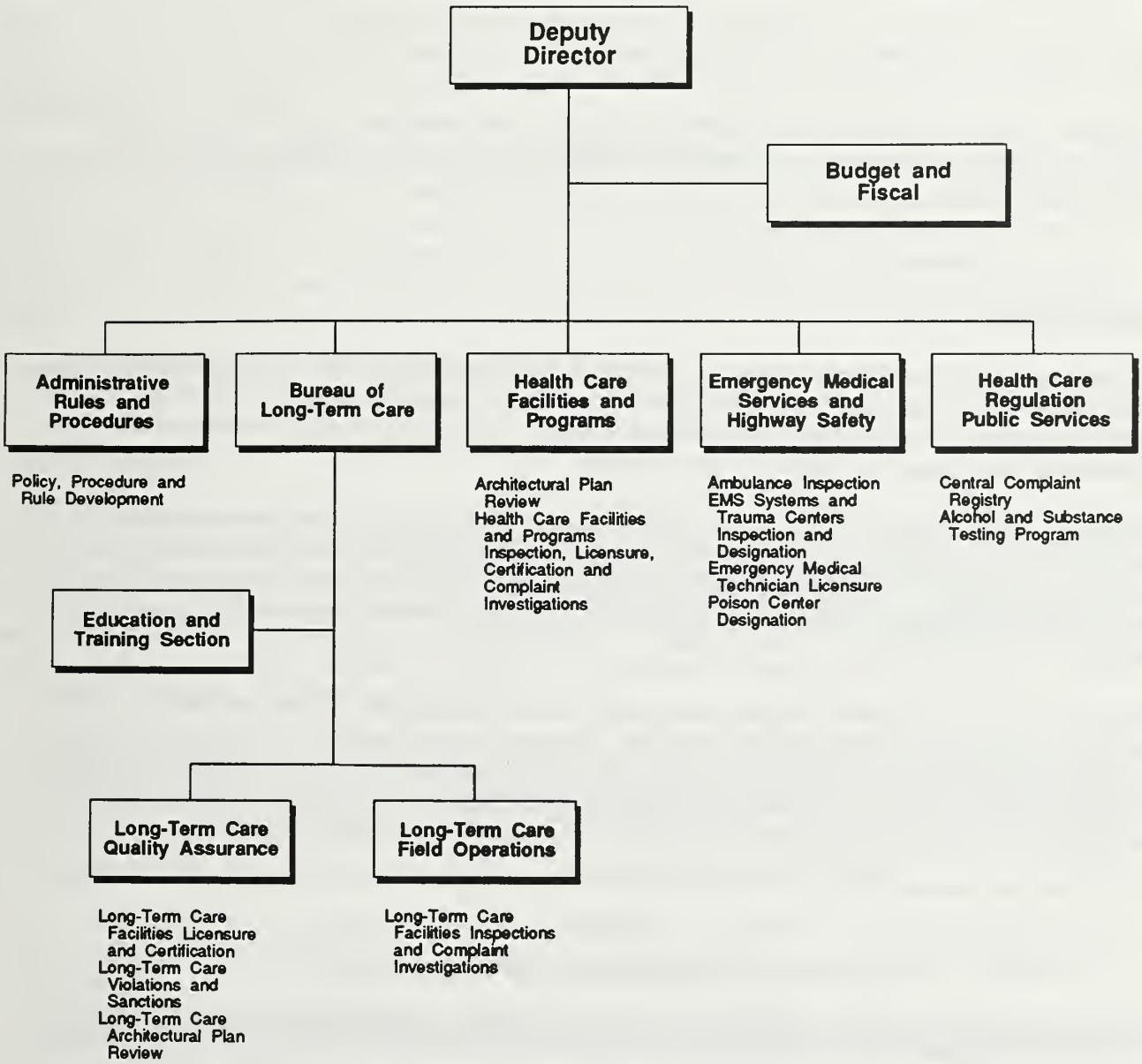
The ***Division of Emergency Medical Services and Highway Safety*** administers regulations for prehospital and interhospital emergency medical care, trauma centers and poison control resource centers. Staff inspect and investigate ambulance services, emergency medical service systems and trauma centers and license emergency medical technicians.

The ***Division of Health Care Facilities and Programs*** administers state and federal regulatory programs including those for ambulatory surgical treatment centers, hospitals, renal dialysis facilities, clinical laboratories, health maintenance organizations, home health agencies, hospices and rural health facilities.

The ***Division of Health Care Regulation Public Services*** administers the Alcohol and Substance Testing program of the "Driving while under the influence..." section of the Illinois Vehicle Code and manages the Central Complaint Registry. The Alcohol and Substance Testing program certifies breath test instruments and licenses breath test instrument operators and laboratories that test human biological fluids for the presence of alcohol and drugs. The division's responsibility for the Central Complaint Registry is to record the information provided by callers. Division staff then forward complaint information to staff of the appropriate OHCR division who investigate the allegations.

Figure 1

Office of Health Care Regulation



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Program Title: **Long-Term Care Regulation**

Goal

To promote quality care services for residents of long-term care facilities, i.e., skilled and intermediate nursing care facilities, community-based and institutional facilities for developmentally disabled persons and sheltered care facilities.

Needs Assessment

Approximately 98,000 individuals reside in more than 1,200 licensed long-term care facilities, known as nursing homes, in Illinois. More than 58,000 of these residents are Medicaid recipients; less than 35,000 are Medicare recipients. Both the elderly persons and younger persons with disabilities who reside in these facilities need the protection of quality of care standards.

The Illinois General Assembly and the U.S. Congress have enacted reforms that recognize residents of long-term care facilities are among the least able to exercise their rights to receive quality medical care and treatment with dignity. The Illinois Nursing Home Care Act established strict licensure standards and provides substantial penalties for violations. The Medicaid and Medicare Certification Programs have similar standards.

The Long-Term Care Regulation program is responsible for the enforcement of state and federal standards governing the operations of long-term care facilities. The program uses inspections as the primary method to evaluate if long-term care facilities continue to meet state licensing and federal certification standards. Architects, dietitians, nurses, sanitarians and qualified mental retardation professionals conduct inspections, which allow the Department to evaluate compliance with state rules and federal regulations.

Table 1

Licensed and Certified Long-Term Care Facilities[1]

Category	Number	State Licensure	Medicare Certification	Medicaid Certification
Nursing Homes				
state licensed only	132	X		
state licensed and Medicare and Medicaid certified	990	X	X	X
Hospitals with				
Long-Term Care Units	36		X	X
Swing Beds[2]	73		X	
State Mental Health Facilities	12		X	X

1. As of January 1, 1993.
2. Beds licensed for dual use: acute or long-term care.

For many years, surveyors evaluated long-term care facilities to determine if systems were in place to allow good care. For example, the adequacy of nursing care was based on the number of nursing staff present for each shift. But in August 1986, the HCFA-mandated Patient Centered survey (PaCs) shifted the focus of evaluating care to outcomes. Instead of counting the number of staff present on each shift, surveyors focused on how well the staff met residents' needs. This outcome-based focus extends to food service, environmental and safety concerns, resident rights, medication administration, social services and recreational activities.

Then in October 1990, the Omnibus Budget Reconciliation Act (OBRA) of 1989 added new survey components and expanded existing components to federal surveys that further increased the time required to complete inspections. HCFA documentation reported that this new process increased survey time by 40 percent.

The above changes significantly increased the time required for conducting inspections of long-term care facilities. In addition, the number of complaints that require on-site investigations increased by more than 600 (16 percent) since 1990. Yet the number of surveyors did not increase proportionally due to state and federal funding reductions. To adequately evaluate the quality of care given to the residents of long-term care facilities, the program must continue to make adjustments to the inspection process that overcome this disparity.

The target population and recipients are all residents of Illinois.

Program Activities

General Overview

The Long-Term Care Regulation program is administered by the Bureau of Long-Term Care (LTC) within the Office of Health Care Regulation (OHCR). Bureau staff derive regulatory authority from two sources. First, as agents of the Health Care Financing Administration (HCFA), bureau staff administer the Medicare and Medicaid certification inspection programs pursuant to Titles 18 and 19 of the Social Security Act. Second, bureau staff inspect, license and enforce the provisions of the Nursing Home Care Act and administrative rules for long-term care facilities.

Recently passed legislation expands the scope of responsibilities of the program. The Supportive Residences Licensing Act authorizes a new category of long-term care facilities to provide services to individuals with human immunodeficiency virus (HIV). Currently the act authorizes six facilities for the city of Chicago ("municipalities with a population over 500,000"). The Department promulgated rules and developed procedures and forms for license applications, which facilities have begun to submit.

As previously stated, the bureau uses the inspections as the primary method of evaluating compliance with state licensing and federal Medicaid and Medicare certification. Descriptions of the four basic types of inspections follow.

Certification inspections take place approximately every nine to 15 months. These inspections evaluate compliance with federal Medicare and Medicaid standards and include specific methods of evaluating how well facility staff meet residents' needs. "Needs" include medical, nutritional, social and recreational services and the provision of a safe and healthy environment.

Licensure inspections occur approximately every six to 18 months to evaluate compliance with rules promulgated under the Nursing Home Care Act. Staff make every effort to conduct the certification and licensure inspection at the same time. The evaluation methods for licensure are similar to certification.

Complaint investigations evaluate the specific issues that a complainant alleges are in noncompliance with state rules and federal regulations.

Follow-up inspections determine if the facility corrected violations and deficiencies.

In January 1992, the Department began to combine licensure and certification reviews of inspections and plans of correction for both state licensure and federal certification programs. This process will improve consistency in citing violations under the state licensure and federal certification programs.

Public Act 87-1102, effective January 1, 1993, amended the Nursing Home Care Act to enable the Department to issue a two-year license. The two-year license reduces the number of inspections for a facility that demonstrates consistent compliance with rules. To be issued a two-year license, the prior two-year record of that facility must meet certain criteria. Those criteria are: no "A" violations, i.e., situations that result in the death, serious mental or physical harm to the resident; no "B" violations, i.e., situations that directly threaten the health, safety or welfare of any resident; no sanctions or decertification for Medicare or Medicaid deficiencies; no more than nine administrative warnings and no order to reimburse a resident due to violation of rights. Department staff prepared rules and developed procedures to carry out the two-year license and identify eligible facilities.

Table 2

LONG-TERM CARE

Target Population and Activity Measures

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
TARGET POPULATION[1]	11,431	11,543	11,552	11,560	11,569	11,857
ACTIVITY MEASURES						
Central Complaint Registry						
calls received	16,648	21,728	22,688	22,270	23,000	23,500
information and referrals	6,158	6,981	7,422	7,960	8,000	8,150
complaints filed	3,907	4,371	4,558	4,728	4,800	4,900
incident reports filed	5,837	9,546	9,768	9,770	9,880	10,130
Inspections						
annual licensure	1,015	1,061	1,053	1,080	1,200	1,400
complaint investigations	3,547	3,926	4,169	4,200	4,250	5,000
follow-up	298	252	189	126	100	100

1. Count in thousands.

All inspections are reviewed by staff who are in the same discipline as those who conducted the inspections. Department staff who review inspection reports decide if there are violations of licensure standards and the appropriate level of violation. The Department notifies the licensee of all inspection results. Department staff evaluate plans of correction for all violations, repeat administrative warnings and initial administrative warnings regarding Sections 3-401 through 3-413 of the Nursing Home Care Act.

Department staff also evaluate inspection reports to decide if facilities meet certification program requirements and make recommendations to HCFA and IDPA. HCFA and IDPA make all final certification decisions regarding facilities receiving Medicare and Medicaid funds, respectively.

Enforcement actions available under the Nursing Home Care Act for licensure include monetary fines, placement of monitors, imposed plans of correction, conditional licensure, license revocation and, in extreme situations, facility closure. Currently, under the federal certification program, the Department may recommend certification or termination, based upon survey deficiencies. With the inception of new federal requirements, other enforcement actions will be available, such as fines, receivership, monitors, imposed plans of correction, etc.

The Department maintains two registries that involve the Long-Term Care Regulation program. The Central Complaint Registry (CCR) has a 24-hour toll-free phone number that people can use to register complaints about facilities. Another OHCR component, the Division of Health Care Regulation Public Services manages the CCR. But, LTC staff investigate complaints concerning long-term care facilities (Table 2). The Nursing Home Care Act requires that all complaint investigations are to be initiated within 30 days. Investigation of complaints alleging abuse or neglect of a resident must be initiated within seven days. Abuse and neglect complaints that suggest a resident is still in danger are investigated as soon as possible, within 24 hours.

The Education and Training Section maintains a registry of persons who have satisfactorily completed nurse aide training. A facility cannot employ a person as a nurse aide unless that person's name is on the registry or is enrolled in a nurse aide training program within a certain time limit. If the Department finds that a nurse aide abused or neglected a resident or misappropriated resident property in a facility, the Department notifies the aide, who is given an opportunity to contest the findings in a hearing before the Department. A written response in lieu of requesting a hearing may be accepted. If after a hearing, or if no hearing is requested, the Department finds that the nurse aide abused a resident neglected a resident, or misappropriated resident property in a facility, the finding is included as part of the information on the registry regarding that individual.

The Education and Training Section provides services primarily in three programs: nurse aide training, surveyor training and provider training. The section reviews and approves submitted nurse aide training programs, monitors each approved program at least biannually, coordinates administration of the nurse aide competency evaluation and provides information concerning nurse aide status upon request.

Additionally, the section provides each newly employed surveyor with a federally approved state basic orientation program within six months of employment and schedules each newly employed surveyor to attend the federal surveyor orientation program within one year of employment. It also provides continuing education to surveyors and participates with the educational community and the health care industry in presentations of programs to inform the industry of new regulations and advances in the health care field.

Program Effectiveness

This program does not lend itself to outcome objectives. A reduction in the number of violations could indicate an effective enforcement program or an ineffective survey process. An increase in violations could similarly mean a success or failure of the program.

One way to measure program effectiveness is to assess the effectiveness of the process. As stated earlier the Nursing Home Care Act mandates the initiation of complaint investigations within specified time limits. The objective is to meet these time limits 100 percent of the time (Table 3).

Similarly, the percentage of surveys that are completely processed within 60 days of the exit (last day of the survey) evaluates the timeliness of administrative and review steps (Table 3).

A third objective relates to facility recidivism for "A" or "B" violations of the Nursing Home Care Act. When a facility fails to follow an imposed ("A" violation) or accepted ("B" violation) plan of correction within a prescribed time, reviewers cite a "Repeat." A reduced rate of "Repeat" violations depicts the effectiveness of the program (Table 3).

Another objective involves the duration that monitors are assigned to a facility. The Nursing Home Care Act authorizes the use of monitors when serious, non-life threatening situations are identified. A monitor acts as the Department's eyes and ears to identify further situations before they have a negative impact on the residents. Further, monitors may observe, provide consultation to facility staff on how to comply with state regulations and report observations to the Department. Monitors are health care professionals from any needed discipline, e.g., nurse, administrator, dietician, sanitarian, etc. The use of a monitor, one of the least intrusive enforcement actions, is very effective with responsive facilities. The use of monitors should continue to increase, since the Department expects HCFA to add this option as an intermediate sanction in their new enforcement regulations to be published in 1994.

Table 3

LONG-TERM CARE

Outcome Objectives and Actual Performance

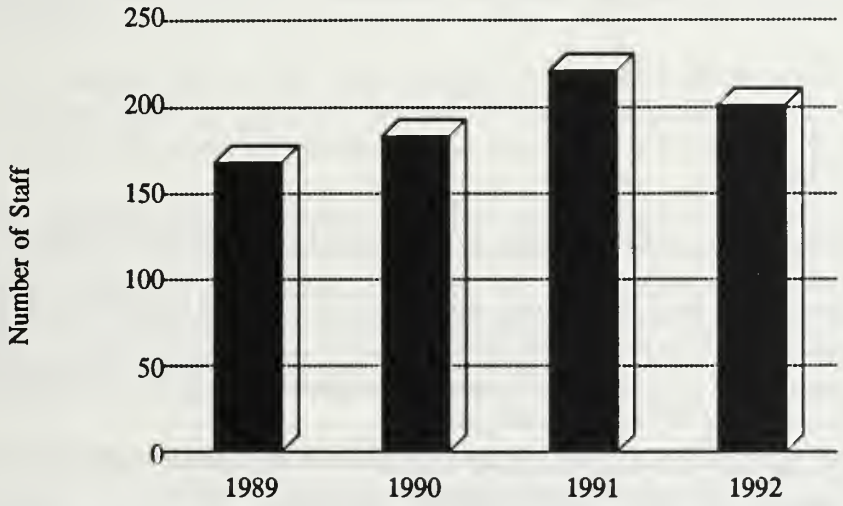
	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
Complaint investigations initiated within statutory time limits (count for outcome objective)[1]	(3,536)	(3,902)	(4,148)	NA	NA	NA
outcome objective	100.0	100.0	100.0	100.0	100.0	100.0
actual performance	99.7	99.4	99.5	NA	NA	NA
Licensure survey reports evaluated and corresponding violation citations determined within 60 days after last exit (count for actual performance)[1]	(101)	(219)	(146)	NA	NA	NA
outcome objective	10.0	20.0	30.0	30.0	30.0	40.0
actual performance	7.4	14.8	9.6	NA	NA	NA
Repeat "A" violations[2]						
outcome objective	NA	NA	NA	0	0	0
actual performance	5	1	0	NA	NA	NA
Repeat "B" violations (count for actual performance)[1, 3]	(18)	(24)	(28)	NA	NA	NA
outcome objective	NA	NA	NA	2.0	2.0	2.0
actual performance	3.8	4.0	5.1	NA	NA	NA
Monitor months[4]						
outcome objective	NA	NA	NA	60	75	90
actual performance	NA	74	49	NA	NA	NA

1. Percent.
2. Situations that may result in the death or serious mental or physical harm of the resident.
3. Situations that directly threaten the health, safety or welfare of a resident.
4. These annual counts indicate the number of months during which a monitor has made at least one visit to a facility.

In all cases the main barrier to meeting objectives is the combination of increased workloads without corresponding increases in resources. Specifically, between July 1, 1990 and June 30, 1991, staff increased by 38, or 21 percent. This is 5 percent, or 10 surveyors, below the number of staff authorized to meet the OBRA mandate. (The 40 percent increase recommended by HCFA would have provided an increase of 73 surveyors for a total of 256.) The decrease in staffing levels of November 1, 1992, resulted from lost vacancies and nine layoffs in the Bureau of Long-Term Care in response to fiscal year 1993 budget constraints (Figure 1). But, the Department continues to explore ways to meet these objectives.

Figure 1

Survey Staff
Illinois: 1989–1992



Source: IDPH, Division of Health Care Regulation

Assurances

Interagency Cooperation

Department licensure of various levels of long-term care facilities requires interaction with other agencies. The Department works closely with the departments of Aging, Children and Family Services, Mental Health and Developmental Disabilities (DMHDD), Professional Regulation, Public Aid (IDPA), Rehabilitation Services (DORS) and Veterans Affairs; Guardianship and Advocacy Commission (GAC); the Illinois Attorney General; State Fire Marshal; and HCFA, Region V. The Department has various types of interagency agreements to ensure that the long-term care regulatory and inspection program operates efficiently, effectively and consistently with the involved agencies.

CCR staff refer calls for long-term care advocacy to the appropriate agencies. Those agencies involved with long-term care advocacy for residents or potential residents are DMHDD, DORS, GAC, IDPA, Equipped for Equality, Illinois Citizens for Better Care and Protection and Advocacy, Inc.

Family Impact

To ensure that long-term care facilities care for residents in a manner and environment that enhance the resident's quality of life, a family and legal representative interview has become part of the survey process. This interview process focuses on issues that relate to the facility's responsibility toward family members or legal representatives, such as:

- resident roommate assignments and intrafacility moves
- notification of rights and services
- involvement in decisions about care and treatment
- notice of changes in resident's health status
- resident's security and personal property
- notification about facility charges
- resolution of complaints and grievances

The bureau's inspections and interview process provide residents and their relatives and friends with the knowledge that facilities are required to meet certain standards and that they are inspected and monitored. If anyone becomes aware of any exceptions, the Department's hotline process provides that individual with a quick way to report those exceptions without fear of retaliation and the individual knows the complaint will be investigated. Inspections, family interviews, the hotline and complaint investigations help promote quality care services.

Recommended Changes to Program

The following are recommended changes to the program, some of which need to be developed:

- work with HCFA to develop a survey process that reduces staff time spent in facilities with few, if any, problems and increase staff time in problem facilities
- use laptop computers routinely to improve the efficiency and effectiveness of the survey process and train staff on the newly developed HCFA software program
- identify, through discussions and comments, situations that surveyors feel require training and develop and present in-service training programs to address those situations
- develop a more efficient survey process that allows OHCR to continue to meet statutory mandates with reduced staff

Legal Citations

Abused and Neglected Long Term Care Facility Residents Reporting Act, 210 ILCS 30/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 4161 *et seq.*)

Community Living Facility Licensing Act, 210 ILCS 35/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 4181 *et seq.)*

Nursing Home Care Act, 210 ILCS 45/1-101 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 4151-101 *et seq.*)

Social Security Act, Titles XVIII and XIX, 42 USC 1395, 1396

Supportive Residences Licensing Act, 210 ILCS 65/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 9001 *et seq.*)

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Program Title: **Health Care Facilities and Programs Regulation**

Goal

To promote quality health care service to consumers by monitoring adherence to minimum standards of quality by health care facilities and programs that require state licensure or that provide services to Medicaid or Medicare recipients.

Needs Assessment

The regulation of health care delivery settings has grown out of two primary needs: to assure that all persons receive an adequate level of quality of care and to assure that public payers, through the Medicare and Medicaid Programs, reimburse only providers who meet minimum standards of quality.

The past ten years have been a period of significant change in the health care delivery system and in the approaches taken by regulatory agencies. The health care delivery system has diversified due to the development of technology and efforts to reduce costs. Many patient services that had been confined to inpatient settings are delivered in the home. Surgery that was done on an inpatient basis is now done on an outpatient basis. Those who previously provided a single type of service have diversified and are combining services in ways never anticipated a few years ago.

As a result of this increasing diversity, regulatory agencies must find ways to become more flexible in defining services. The familiar pigeonhole approach no longer matches the organization of the health care industry. For example, a hospital is no longer just a hospital. It may now be a long-term care facility, a home health agency, a dialysis center and an outpatient clinic. Similarly, many home health agencies have expanded beyond their traditional home health services by providing intravenous therapy, transfusions, dialysis services and durable medical equipment. In addition, ambulatory surgical treatment centers assert that they can provide short term overnight recovery care for patients more economically than can hospitals.

During the past decade, state and federal regulatory agencies changed the focus of standards and survey approaches from the elements of care to the outcome of care. Recent revisions of the Medicare certification survey protocols for home health agencies are an example of this change. The surveyor focus for assessing patient care changed from reviewing agency policies, procedures and number of staff to direct observation during visits to patients' homes and reviews of individual patient records. To accommodate these changes, the approach to regulation must shift from regulating different types of facilities and agencies to regulating provider services. Other states are trying an umbrella regulatory statute with provisions allowing the regulatory agency to define services and establish the standards. It is an approach that should be considered in Illinois.

In 1988, another change occurred at the federal level that affected the division and other state licensure programs nationwide. Congress passed the Clinical Laboratory Improvement Amendments (CLIA) of 1988, which require providers of any diagnostic laboratory testing to obtain a certificate from the federal government: in effect, licensure at the federal level. Congress passed a similar measure in the fall of 1992 for providers of diagnostic and screening mammography services. These measures represent a distinct departure from the regulatory scheme of the past when states established the licensure standards for provider services while the federal government established standards for participation in payment programs.

One effect of this change is Illinois' response to the implementation of CLIA. A variety of factors required Illinois to repeal its own clinical laboratory licensing statute in favor of the federal program. The change reduces the control that the state's executive and legislative branches have over the standards these providers are required to meet in our state. Many individuals and organizations believe that this change actually reduces the quality of laboratory services in Illinois.

The target population for these activities is the entire population of Illinois. Most residents come into contact with the health care delivery system at some point, either personally or through the illness of a family member or friend.

Program Activities

General Overview

The Health Care Facilities and Programs Regulation program is administered by the Division of Health Care Facilities and Programs, within the Office of Health Care Regulation. To achieve its goal of assuring that health care facilities and programs maintain established standards of quality, the division develops clear and concise rules and regulations; reviews all plans for construction, expansion or remodeling of health care facilities; conducts initial and annual licensure and certification surveys and follow-up visits to ensure that facilities and programs have completed plans of correction; investigates complaints lodged with the Department and enforces sanctions prescribed by the licensure and certification statutes and regulations. In addition, the division consults with providers regarding the regulations, their meaning and appropriate practices of health care delivery.

The primary method of assuring adherence to minimum standards of quality health care is on-site inspections. Depending on the program, inspection teams composed of nurses, sanitarians, architects, nutritionists, laboratory evaluators and nuclear safety inspectors conduct initial and annual licensure, certification or combined licensure and certification surveys to assess compliance with published standards. Survey staff identify deficiencies and communicate in writing to the licensee who must submit a written plan of correction. Staff also do follow-up inspections to assess the corrective action.

The division's Central Office Operations Section evaluates complaints received directly from the community and referred by the Department's Central Complaint Registry, a toll-free hotline. Staff schedule on-site complaint investigations according to the risk to human life alleged by the complainant and in compliance with various time limits mandated in Department regulations. These complaint investigation inspections are similar to the initial and annual licensure and certification inspections. Staff from the division's Field Operations Section, Standards Section, Laboratory Regulation Section, or the Long-Term Care Field Operations conduct the investigations. Inspectors identify deficiencies and communicate in writing to providers who must submit a written plan of correction. Appropriate staff do follow-up inspections to assess the corrective action.

If the provider will not or cannot correct deficiencies, or if the deficiency is an immediate and serious threat to the health and safety of service recipients, staff take enforcement action. In the case of licensure, sanctions may include conditional licensure, license revocation, immediate temporary or permanent closure of the program or facility and the imposition of fines. Statutes define the limits of Department sanctions.

In the case of Medicare certification, the division recommends termination of participation in the program to the federal Health Care Financing Administration (HCFA) when the provider fails to meet all Conditions of Participation in the Medicare program. Termination results in loss of payment for and the ability to serve both Medicare and Medicaid recipients. Situations constituting an immediate and serious threat result in termination within 23 days. Less serious situations may result in termination within 90 days, if not corrected within 45 days.

Table 1

HEALTH CARE FACILITIES AND PROGRAMS

Summary of Responsibilities[1]

	Number	State Licensure	Medicare Certification	Federal Licensure
Ambulatory surgical treatment centers	69	X	X	
Chiropractors[2]	130		X	
Clinical laboratories[3]	4,500			X
Community mental health centers[4]	2		X	
Comprehensive outpatient rehabilitation facilities	8		X	
End-stage renal disease facilities	99		X	
Health maintenance organizations	36	X		
Home health agencies	348	X	X	
Hospice programs	81	X	X	
Hospitals	242	X	X	
Mammography screening clinics	251		X	
Occupational therapist in independent practice[5]	3		X	
Physical therapy and speech pathology services	37		X	
Physical therapist in independent practice[5]	112		X	
Portable X-ray services	19		X	
Rural health clinics	28		X	
Sperm and tissue banks	25		X	

1. As of January 1, 1993.
2. The division processes initial applications for Medicare certification of chiropractors. No inspection or annual renewal is required. The number indicated is an average of the annual number processed.
3. Includes independent laboratories, hospital laboratories, blood banks, screening entities and physician office laboratories.
4. The division processes initial certification applications. No inspection or annual renewal is required. The number reflects those certified to date.
5. An initial certification application and inspection is required. No annual renewal or reinspection is required. The number reflects currently certified providers.

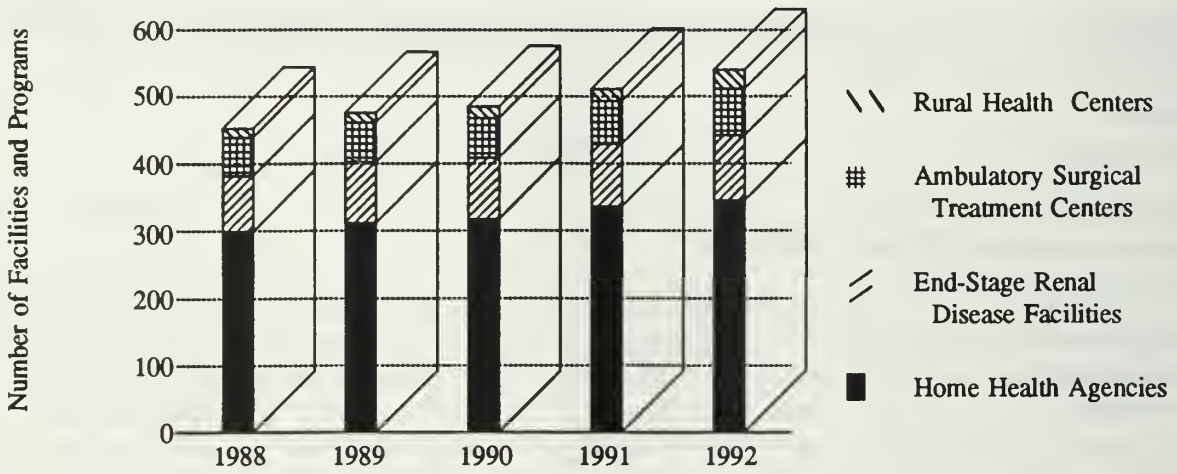
The Clinical Laboratory Improvement Amendments (CLIA) of 1988 include a range of sanctions—from fines to loss of license—to deal with laboratories that do not comply with CLIA requirements. As with other Medicare-certified providers, the Department recommends the appropriate sanctions to HCFA for final determination and action.

The division coordinates licensure and certification actions and emphasizes the enforcement action that achieves the quickest provider compliance. Strengthened federal procedures for termination of noncompliant providers support the division's efforts.

The division's workload increased significantly over the last few years as the result of changes, e.g., advances in medical technology and increasing restrictions on Medicare and third party reimbursement for inpatient care. Hospitals discharge patients with complex medical problems sooner and refer the patients to high-tech outpatient centers or for follow-up care in the home. The result is a significant increase in the number of ambulatory surgical treatment centers, outpatient renal dialysis facilities and home health agencies (Figure 1). The number of rural health clinics more than doubled in the past two years due to the emphasis on making primary care available in medically underserved areas and increasing reimbursement for such care (Figure 1).

Figure 1

Number of Facilities and Programs
Illinois: 1989–1992

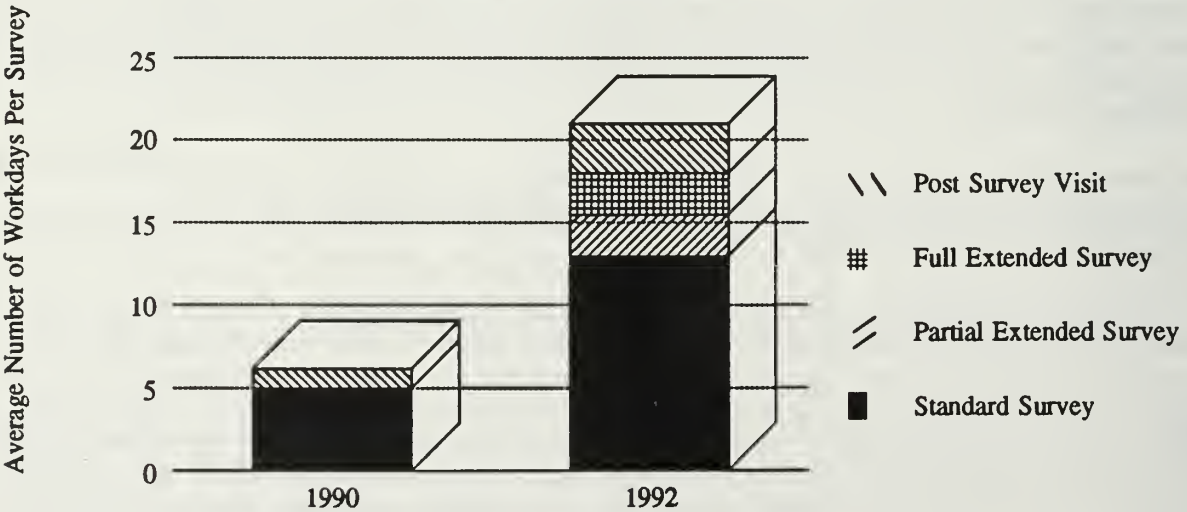


Source: IDPH, Division of Health Care Regulation

HCFA changed the survey process for certification of home health agencies during fiscal year 1991. Previously, the survey was process and task-oriented: surveyors reviewed corporate documents, policies and procedures, meeting minutes, personnel files and other agency documents to determine compliance. The new process is outcome-oriented and focuses on evaluating the quality of patient care. The survey includes extensive clinical record reviews and patient home visits. When survey staff identify problems, they must extend the survey to include a review of the agency's policies and procedures, personnel records and additional patient records. This new process provides a much clearer evaluation of the quality of patient care but is much more labor intensive. Survey time has doubled, and in some cases, tripled (Figure 2).

Figure 2

Comparison of Survey Time at Home Health Agencies
Illinois: 1990 and 1992



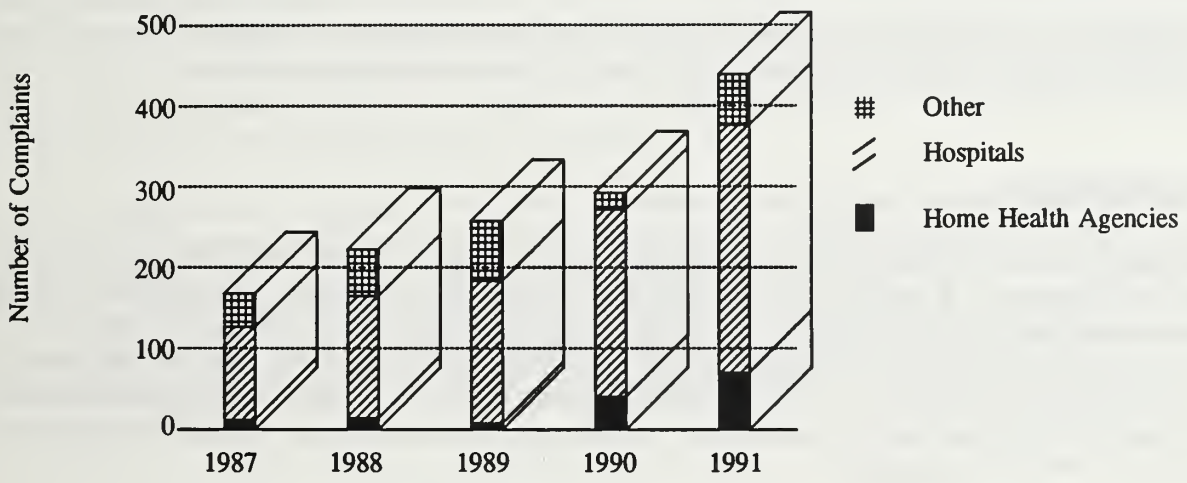
Source: IDPH, Division of Health Care Regulation

Newly implemented HCFA programs also increased the division's workload. Beginning December 1990, HCFA required Medicare certification of mammography screening clinics. Division staff certified these facilities through paper compliance through fiscal year 1992. Beginning fiscal year 1993, HCFA required on-site surveys of the 249 certified mammography screening clinics and new applicants for Medicare certification. In addition, Medicare certification of outpatient community mental health centers began at the end of fiscal year 1992. HCFA requires only paper compliance, but division staff expect that on-site surveys will be required in the future.

Another factor contributing to workload demands is the increasing number of complaints against regulated health care providers. The most significant increases have been against hospitals and home health agencies (Figure 3).

Figure 3

Complaints Regarding Health Care Facilities and Programs[1]
1987–1991



1. Does not include long-term care facilities

Source: IDPH, Division of Health Care Regulation

Table 2 reflects key activities of the division during the past several years. Division architectural and engineering staff review plans for construction and remodeling of health care facilities to ensure compliance with the physical plant standards of the Department and the appropriate provisions of the National Fire Protection Association's Life Safety Code. On-site construction inspections are also conducted when construction or remodeling is completed.

The variance between the number of plan reviews completed and the number of construction inspections completed arises because staff conduct several plan reviews for each project (Table 2). The decrease shown between fiscal years 1990 and 1992 reflects the transfer of responsibilities for the review of long-term care facility plans and construction from the division to the Bureau of Long-Term Care and reduced staff levels. An increase in staff levels projected for fiscal year 1994 should result in increased plan review efforts.

The number of surveys reflects the number of licensure or certification surveys completed for facilities and programs and does not reflect the number of disciplines or individual surveyors who participate in any given survey. One or two nurses may conduct a survey or a survey may involve an entire team of nurses, architects, sanitarians, nutritionists and laboratory inspectors. When both certification and licensure surveys are conducted during one visit, the surveys are counted separately.

Table 2

HEALTH CARE FACILITIES AND PROGRAMS

Activity Measures

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
ACTIVITY MEASURES						
Plan reviews completed	1,260	992	773	800	990	1,500
Construction inspections completed	273	219	244	250	250	500
Licensure and certification surveys completed	1,835	2,245	2,520	3,583	4,000	7,000
Complaint investigations completed	191	205	296	517	600	1,000
Licensure and certification enforcement actions initiated	42	35	40	45	50	85

The estimated fiscal year 1993 and projected fiscal year 1994 numbers reflect anticipated workload. Given state and federal budget cuts and constraints, not all survey activities may be completed.

Program Effectiveness

The division uses two quantifiable outcome-oriented measures to show the effectiveness of the program. One measure is the percentage of providers who comply with licensure and certification requirements or regain compliance through a plan of correction prior to the Department taking formal enforcement action. The second measure is the percentage of providers who comply with the requirements after the Department takes formal enforcement action (Table 3). The Department believes that the high level of performance on these indicators supports the monitoring of health care providers and the consistent application of appropriate sanctions to get provider compliance.

Table 3

HEALTH CARE FACILITIES AND PROGRAMS

Outcome Objectives and Actual Performance

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
Providers in compliance or who come into compliance without formal enforcement action initiated[1]						
outcome objective	98	98	98	98	98	98
actual performance	95	95	99	NA	NA	NA
Certification actions resulting in achievement of provider compliance and recertification[1]						
outcome objective	99	100	100	100	100	100
actual performance	100	99	99	NA	NA	NA

1. Percent.

In fiscal year 1992, 98.5 percent of providers complied with or came into compliance without formal enforcement action being initiated, exceeding the target by one-half percent. Also in fiscal year 1992, 99.9 percent of providers avoided decertification; one provider was decertified.

Currently, the greatest threat to program effectiveness is dwindling financial resources. The General Assembly significantly reduced the General Revenue Funds (GRF) that supported licensure programs for fiscal years 1991 and 1992. These reductions and early retirement and unfilled vacancies resulted in staff reductions. This trend continues in fiscal year 1993.

The division made a fiscal year 1993 budgetary decision to base licensure of home health agencies and hospices on compliance with Medicare Certification requirements, eroding the division's GRF base by six positions. Unfilled vacancies from the 1991 early retirement program have severely hampered the division's ability to conduct physical plant and fire safety plan reviews and on-site inspections in hospitals and ambulatory surgical treatment centers. During this period of staff reductions, the division's workload increased (Table 2).

Funding for Medicare certification activities is reduced. In fiscal year 1991, the Department received a significant increase in Medicare funds to finance changes in survey methods that quadrupled the survey time previously required in home health agencies and doubled the survey time in renal dialysis facilities. The division completed the corresponding survey staff increases in federal fiscal year 1992. But, during federal fiscal year 1993, HCFA mandated the screening of mammography providers, requiring additional survey time, without providing any corresponding increase in funding.

Insufficient support for both licensure and Medicare certification activities threatens the Department's ability to carry out these programs effectively and to assure the public that facilities and programs are providing a minimally acceptable level of quality of care in a safe environment. In addition, the increasing complexity of services provided in less intensive health care settings and the rapid growth of technology continually gives regulators new challenges. Lack of resources impedes division efforts to keep up with the industry in both regulation development and survey technology. Inability to respond to new developments will impede future program effectiveness.

Assurances

Interagency Cooperation

One type of interagency cooperation involves enforcing existing statutes and rules. Some specific examples follow.

Mammography Screening—The Department works with the Department of Nuclear Safety to conduct certification inspections of mammography screening clinics. Nuclear safety inspectors inspect the equipment and review technical aspects of equipment in the facilities and health facilities surveillance nurses from the division review personnel and patient care issues.

Health Maintenance Organization (HMO) Certification—The Department shares joint responsibility with the Department of Insurance for certification of HMOs. The Department reviews application and conducts inspections to assure the Department of Insurance that HMO providers have the capacity to enhance the availability, accessibility and continuity of care for HMO members.

Provider Practice Referrals—The Department informs the Department of Professional Regulation of questionable practices by specific care givers whom the latter certifies, licenses or registers.

A second type of cooperative effort pertains to the process of recommending changes to statutes and administrative rules. The division seeks advice from health facility administrators, medical professionals, consumer organizations, other government agencies and a variety of other sources to ensure that revised statutes and rules are clear and concise. In addition, the division staff spend considerable time working with several advisory boards to assure the public and regulated providers an opportunity to participate in this process.

Family Impact

The restorative and rehabilitative health care services offered by the various programs regulated by the division help improve the physical condition of individuals and the emotional aspects of family life.

Recommended Changes to Program

Specific challenges face the division in the coming year. Staff need to establish regulations for the use of computers in provider settings and licensing standards for the subacute care hospital, which is the first category of services authorized by the Alternative Health Care Delivery Act. Also, staff need to identify changes that can make more effective and efficient use of dwindling resources.

Legal Citations

Ambulatory Surgical Treatment Center Licensing Act, 210 ILCS 5/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 157-8.1 *et seq.*)

Civil Administrative Code of Illinois, 20 ILCS 2310/55.20 (Ill. Rev. Stat. 1991, ch. 127, ¶ 55.20)

Civil Administrative Code of Illinois, 20 ILCS 2310/55.45 (Ill. Rev. Stat. 1991, ch. 127, ¶ 55.45)

Clinical Laboratory Improvement Amendments of 1991, § 353 of the Public Health Services Act, 42 USC § 263a

Health Maintenance Organization Act, 215 ILCS 125/1-1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 1401 *et seq.*)

Home Health Agency Licensing Act, 210 ILCS 55/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 2801 *et seq.*)

Hospice Program Licensing Act, 210 ILCS 60/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 6101 *et seq.*)

Hospital Licensing Act, 210 ILCS 85/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 142 *et seq.*)

Illinois Blood Bank Act, 210 ILCS 10/1-101 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 601-101 *et seq.*)

Illinois Clinical Laboratory Act, 210 ILCS 25/1-101 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 621-101 *et seq.*)

Social Security Act, Titles XVIII and XIX, 42 USC, § 1395 and 1396

4R_C_HCF.HSP

Program Title: **Emergency Medical Services Regulation and Systems Development**

Goal

To reduce mortality and morbidity resulting from injuries and medical emergencies.

Needs Assessment

Injuries from motor vehicle accidents, other trauma, cardiac and other medical emergencies require immediate response to minimize potential disability or death. Adequate response to such events can be provided only through an emergency response system that includes the following components: transport vehicles and equipment meeting national standards; communication systems linking vehicles to hospitals; trained, licensed ambulance personnel and medical facilities staffed and equipped specifically to handle emergencies.

A long-range financial plan to ease the burden of hospitals absorbing the cost of care for those who cannot pay is critical to ensure that all Illinois residents have access to emergency medical services (EMS). Trauma Centers have experienced crippling financial losses from providing sophisticated treatment to critically injured patients who are uninsured or inadequately insured. Rural providers of EMS experience additional financial burdens.

The closing of many rural hospitals has rendered ambulance service the only source of medical assistance in many communities. Usually these services depend on volunteers, leading to problems ensuring adequate refresher training enrollment and maintenance of skills.

The target population of the EMS Program is all Illinois residents.

Program Activities

General Overview

The Emergency Medical Services Regulation and Systems Development program is administered by the Division of Emergency Medical Services and Highway Safety within the Office of Health Care Regulation. To achieve the program goal, division staff establish, monitor and enforce EMS regulations. EMS, under the Emergency Medical Services Systems Act ("Act"), refers to an organized, coordinated network of prehospital and interhospital personnel and ambulance services and hospital emergency department staff that respond to the needs of the acutely sick and injured.

In Illinois, only an "EMS System" approved by the Department can provide and coordinate prehospital care at an advanced or intermediate level. The Project Medical Director of each EMS System has total responsibility for all aspects of prehospital and interhospital care. This responsibility includes medical control and oversight of infield patient care through an ambulance-to-hospital communications system. Each EMS System, led by a resource hospital, may have associate and participating hospitals. The resource hospital prepares a comprehensive EMS System Plan that defines the roles and responsibilities of system participants. Division staff review all components of the EMS System Plan at the time of initial application and review individual updated and amended portions.

A 1986 amendment to the Act established trauma center regions and gave the Department authority to designate Trauma Centers. The Department designated 11 trauma regions and Level I and Level II trauma centers for each region. Each Level I trauma center serves as the lead hospital in the development of a Trauma Region Plan and in monitoring the quality of trauma care provided within each region. The Act requires each Level I trauma center to "provide all essential services, as determined by the Department by rule, in-house, 24 hours per day." A Level II trauma center must "have some essential services available in-house, 24 hours per day and other essential services readily available 24 hours per day, as determined by the Department by rule." The Act requires trauma centers to participate in an EMS System to ensure coordination and involvement of EMS System participants. Program staff maintain a trauma case registry.

The Act requires the Department to license providers who are not supported by units of local government. But some ambulance providers not licensed by the Department request Department inspection for third party payor eligibility. The Act requires all intermediate or advanced level ambulance providers to participate in an EMS system. The Act provides for the licensure and regulation of specialized emergency medical services vehicles: ambulances, helicopters, fixed-wing aircraft, watercraft and off-road vehicles used to carry patients. Division staff inspect all vehicles covered by the Act annually.

The division licenses and regulates several categories of individuals. Staff issue three levels of emergency medical technicians (EMTs) licenses. An EMT-Ambulance (EMT-A) is the entry level license given to a person who has successfully completed training in airway management, cardiopulmonary resuscitation, control of shock and bleeding and splinting of fractures. The division issues an EMT-Intermediate (EMT-I) license to an EMT-A who receives training in advanced airway techniques and initiating intravenous fluids. The division issues an EMT-Paramedic (EMT-P) license to an EMT-A or an EMT-I who receives additional training in advanced life support. EMTs must complete training approved by the division and pass a licensure examination prepared by the division or the National Registry of Emergency Medical Technicians. Program staff monitor the quality of EMT instruction through review of training programs and practical and written exams. To retain their license, EMTs must complete annual continuing education that is approved and reviewed by the division. The Act requires EMT-Is and EMT-Ps to function only within Department-approved EMS systems. There are 27,985 active EMTs licensed in Illinois.

Table 1

EMERGENCY MEDICAL SERVICES AND SYSTEMS DEVELOPMENT

Target Population and Activity Measures

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
TARGET POPULATION[1]	11,431	11,543	11,552	11,560	11,569	11,857
ACTIVITY MEASURES						
EMTs licensed[2]	4,854	5,953	6,059	6,500	7,000	10,000
Ambulances licensed	1,829	1,829	2,049	2,026	2,084	2,490
Helicopters certified	6	10	10	10	10	16
Trauma centers designated	78	78	78	74	74	74
EMS systems approved	38	47	51	52	54	56

1. Count in thousands.
2. Represents individuals newly licensed as EMT-As, EMT-Is, EMT-Ps and EMT-Cs each year.

Department regulations also establish standards for the approval of registered nurses, who may be used by an EMS system as ambulance personnel and mobile intensive care nurses who may be approved by a Project Medical Director to provide online medical control to ambulance personnel. In addition, the division also provides training standards for a trauma nurse specialist course. Finally, the division certifies EMT-Coal miners (EMT-C) pursuant to the Coal Mine Medical Emergencies Act.

Division staff review applications and conduct inspections for granting or renewing various licenses, approvals and designations; review requests for waivers of specific regulations and investigate complaints concerning alleged violations of the Act or rules by regulated entities. The division also maintains first aid stations in the Capitol, Centennial and Stratton buildings in Springfield where registered nurses provide emergency medical care to employees and visitors. In addition, the division coordinates a statewide poison treatment program through the designation of Regional Poison Resource Centers, which provide around-the-clock services through toll-free telephone numbers. The recently enacted Poison Control System Act will allow designated hospitals participating in the previously voluntary program to receive funding when the General Assembly appropriates the funds. The division also has a public education program in which ambulance personnel present accident prevention programs in their local communities.

The division receives advice on program and rulemaking activities from the state Emergency Medical Services Council and provides administrative support to the council for its quarterly meetings and interim committee meetings.

Program Effectiveness

General

Trauma centers will benefit from the Trauma Center Fund amendment (PA 87-1229) to the Emergency Medical Services Systems Act. A portion of fines collected for violation of the Illinois Vehicle Code are allocated for trauma center grant programs administered by the Department of Public Aid and the Department. The Department expects that the distribution of an estimated $2.5 million per annum of its portion of the allocation will be used by trauma centers to offset the cost of treating uninsured or inadequately insured patients.

Program staff are responsible for maintaining two of the registries authorized by the state legislature. The Trauma Registry contains data on trauma cases for the period July 1, 1991 through June 30, 1992. Several institutions use this registry for research projects. Although hospitals continue to submit data for the Head and Spinal Cord Injury Registry, lack of funding prevents data entry.

Outcome Objective

Table 2

EMERGENCY MEDICAL SERVICES AND SYSTEMS DEVELOPMENT

Outcome Objective and Actual Performance

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
Population covered by advance life support (ALS) or intermediate life support (ILS) ambulance services[1, 2]						
outcome objective	85	85	85	86	87	90
actual performance	83	84	86	NA	NA	NA

1. Percent.
2. Hospital supervised emergency medical intensive care provided in transit to a hospital (ALS, ILS) or between hospitals (ILS) according to a Department approved plan.

Assurances

Interagency Cooperation

The division works closely with the Illinois Department of Transportation, Bureau of Traffic Safety. Highway Safety Program funds have been used to implement trauma center designations and develop a traffic accident prevention public education program.

Family Impact

Prompt, skilled care by ambulance services and sophisticated trauma care for the critically injured help reduce family stress. In addition, reduction of mortality and morbidity from injuries serves to strengthen Illinois families.

Recommended Changes to Program

As previously indicated, the Department expects that the distribution of an estimated $2.5 million per annum of its portion of the allocation will be used by trauma centers to offset the cost of treating uninsured or inadequately insured patients. But, similar initiatives are needed to maintain the solvency of prehospital care providers in rural areas. New methods of providing services must be explored and a long-range financial plan developed that will ensure Illinois residents access to emergency medical care.

Legal Citations

Choke-Saving Methods Act, 410 ILCS 10/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 56½, ¶ 601 *et seq.*)

Coal Mine Medical Emergencies Act, 410 ILCS 15/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 9½, ¶ 3951 *et seq.*)

Emergency Medical Services (EMS) Systems Act, 210 ILCS 50/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 5501 *et seq.*)

Head and Spinal Cord Injury Act, 410 ILCS 515/0.01 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 7850 *et seq.*)

Poison Control System Act, 410 ILCS 47/1 *et seq.*

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Program Title: **Alcohol and Substance Testing**

Goal

To ensure that law enforcement agencies have trained breath test instrument operators and effective methods to analyze the level of alcohol and drugs in motor vehicle drivers.

Needs Assessment

Traffic accidents in the United States are the greatest single cause of death for persons 5 years of age through 32 years of age. Almost half these fatalities are the result of alcohol-related accidents. Each year alcohol-related crashes kill 22,000 persons and injure an additional 355,000 persons. It is difficult to know the precise number of fatalities and injuries or estimate the dollar value of property destroyed because of wide variances in recordkeeping by federal and state governments.

Effective legislation in Illinois enabled local and county agencies to increase DUI (driving while under the influence) enforcement efforts. The legislation also led to greater demands to train police officers as breath test operators and to provide effective test equipment. The Division of Health Care Regulation Public Services (HCRPS), in cooperation with Illinois State Police and the University of Illinois Police Training Institute, recently reviewed and revised all training to ensure effective operator training. In addition, the replacement and upgrading of breath test instruments and the regular certification and maintenance of the units have increased the efficiency of the program.

Illinois statute requires this program to serve a specific segment of the total state population—licensed breath test operators of police departments in Illinois. Of more than 27,200 authorized and sworn police officers within the state, 9,215 are currently licensed breath test operators.

The monthly certification and maintenance of breath test instruments and annual certification of laboratories and licensure of operators increase the chances that breath test analysis of motor vehicle drivers arrested for DUI will be accurate. Accurate test results increase the likelihood that those whose breath or blood alcohol test exceeds .10 breath alcohol content (BrAC) or blood alcohol content (BAC), respectively, will be convicted.

Program Activities

General Overview

The Alcohol and Substance Testing program is administered by the staff of the Division of Health Care Regulation Public Services within the Office of Health Care Regulation. The Department furnishes breath analysis instruments to local and county police agencies throughout the state. But, a few municipalities have purchased their instruments. These instruments, whether they belong to the Department or local police agencies, must be certified at least once a month at intervals not to exceed 45 days to ensure accuracy. Five models of instruments are currently in use. The 11 Department field inspectors have extensive backgrounds in certification and basic maintenance of these instruments.

The Department also certifies laboratories that do blood and urine analysis for alcohol and other drugs and licenses technicians who conduct the tests. Currently 26 laboratories (including the Department's own laboratory) are certified and 238 technicians are licensed to conduct these analyses.

Department field inspectors train police officers who operate breath analysis instruments. After the successful completion of a 32-hour training program, the police officer is licensed for one year. Thereafter the officer is relicensed annually by showing proficiency in conducting tests on a breath test instrument. Every two years the police officer must take a written test.

The accuracy of the breath test analysis equipment, laboratories and operators comes into question when an offender is prosecuted for DUI. Generally, the program receives approximately 600 subpoenas per year; approximately 125 are *subpoenas duces tecum* (requests for documents) and the remainder for appearances to testify. Each field inspector receives an average of one subpoena to appear per week.

Program Data

Table 1

ALCOHOL AND SUBSTANCE TESTING

Target Populations, Recipients and Activity Measures

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
TARGET POPULATIONS						
Illinois residents	11,430,602	11,543,000	11,552,000	11,560,000	11,569,000	11,852,000
Police officers authorized in Illinois	27,038	27,100	27,200	27,300	27,500	30,000
RECIPIENTS						
Police breath test operators	7,728	8,000	9,489	9,000	9,600	14,200
ACTIVITY MEASURES						
Breath test instruments in service	460	445	425[1]	410[2]	420	500
Breath test instrument certifications	5,520	5,340	5,040	5,000	5,000	6,000
Police officers initially licensed	423	790	602	600	600	600
Police officers relicensed	7,305	7,710	8,887	8,400	9,000	13,600

1. Decertification of 25 Smith and Wesson 1000 breath test instruments in January 1991 due to discontinuance of replacement parts.
2. Decertification of 20 Breathalyzer 2000 breath test instruments due to discontinuance of replacement parts.

Program Effectiveness

Department-approved vendors significantly increased their training activity. The number of police officers licensed to conduct breath alcohol testing throughout the state has increased dramatically from 7,728 in 1990 to an estimated 9,600 in 1994. The program trains 50 new operators each month. Increasing the number of licensed operators helps local police agencies staff qualified breath test operators 24 hours a day.

Yet, certain factors have combined to reduce the effectiveness of the breath test program in Illinois in a way not foreseen in 1972. After passage of a 1971 amendment to the Implied Consent Act, the Department began to supply local police agencies with the Smith Wesson Corporation Breathalyzer Model 1000, issuing these instruments to approximately 350 local police agencies during that year. The Breathalyzer 1000, state of the art in 1972, is now obsolete. Illinois' program has fallen behind other states that are using more sophisticated breath test instruments.

All Breathalyzer Model 1000s were replaced by 1991 with the more effective breath test instrument—Intoximeter 3000. However, there are still 71 other breath test instruments that have been in use for more than 10 years. In future years, the program hopes to maintain a regular process of instrument replacement and upgrading so that no instrument will be used for more than 10 years. But, with the recent budget cuts that eliminated the purchase of new breath test analysis instruments in fiscal year 1993, this seems unlikely.

Outcome Objectives
Although this program does not lend itself to outcome objectives, it can ensure that test instruments function properly and operators properly carry out procedures. The counts of the following measure the effectiveness of the process: the number of breath test instruments in service; the number of breath test instruments certified and the number of initial breath test operators licensed and relicensed annually (Table 1).

Assurances

Interagency Cooperation
Department staff consult and review lesson plans and other materials with the Breath Alcohol Unit of the Illinois State Police in a coordinated effort to implement the implied consent statute.

The division works closely with public and private vendors to develop training programs. One division inspector uses two-thirds of his time teaching the technical aspects of breath analysis to police personnel attending the initial licensure classes at the Police Training Institute.

Family Impact
The serious injury or death of 18,850 family members in Illinois DUI-related motor vehicle accidents is tragic and a severe burden on family members. The arrest of a person for DUI, particularly the head of a household, can negatively impact the family. The loss of a driver's license through the suspension process, even for a short time, can mean the end of employment and cause serious disruption in the family. Strict enforcement and accurate testing, combined with comprehensive and widespread preventive educational programs, have helped reduce this impact.

Recommended Changes to Program

Division staff have several major concerns that require additional funding. As previously indicated, approximately one-sixth of the breath test instruments need to be replaced. Program staff must continue to increase professional training and public information efforts to reach such groups as lawyers and judges in addition to continuing the current support given to local police departments, medical examiners and coroners through the purchase of standardized blood testing kits. Also, the installation of a management information system capable of supporting electronic exchange of information regarding test results would improve the efficiency and effectiveness of the program.

Legal Citations

Counties Code, 55 ILCS 5/3-3001 (Ill. Rev. Stat. 1991, ch. 34, ¶ 3-3001)

Illinois Vehicle Code, 625 ILCS 5/11-501 *et seq.* (Ill. Rev. Stat. 1991, ch. 95½, ¶ 11-501 *et seq.*)

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CHAPTER V

OFFICE OF EPIDEMIOLOGY AND HEALTH SYSTEMS DEVELOPMENT

Introduction

Mission

To facilitate the development of state health policy that assures effective, accessible and affordable health services in Illinois.

Summary of Responsibilities

Program Overview

The Office of Epidemiology and Health Systems Development's (OEHSD) programs assess the health needs, disease occurrence and health status of Illinois residents. The office develops and promotes the use of sound and systematic knowledge bases in health program management, evaluation and policy development. OEHSD provides leadership within the Department in translating data into useful information.

To improve health status and contain health care costs, the office coordinates or conducts data collection, health status surveillance, epidemiologic studies, policy and financial analysis, internal departmental planning, community health planning, health care facilities planning and certificate of need review. Much of the productivity takes the form of technical assistance to the Governor, General Assembly, other sections of the Department, local health departments (LHDs), other state agencies, health care providers and the general public. Staff may assist with needs assessment, data analysis, understanding regulatory requirements, program development and program evaluation.

The office conducts special studies of a broad range of health problems facing the Department and the state. These studies examine risk factors and other epidemiologic indicators of health status, need for service, financial feasibility of health care alternatives, cost containment and service accessibility.

The office produces the state's annual vital statistics report and publishes special reports concerning the health status of particular segments of the population. As Illinois' agent for the Federal-State Cooperative for Population Estimates, the office produces population estimates which are used in defining health indicators. This information is necessary to study characteristics of populations so that resources can be distributed effectively to improve the health of Illinois residents. The office developed and maintains the Illinois Health and Hazardous Substance Registry (IHHSR) for decision making and public health policy making on health problems related to cancer incidence, adverse pregnancy outcomes, occupational diseases and hazardous substances.

The office supports the Illinois Health Facilities Planning Board (IHFPB) in administering the Illinois certificate of need program, enforcing the recently enacted Health Care Worker Self-Referral Act and carrying out planning functions related to health care facilities. These activities are intended to ensure that appropriate financial investments in health care facilities occur. The office has primary responsibility within the Illinois Department of Public Health for administration of the Life Care Facilities Act. Finally, the office has principal responsibility for coordinating the Department's internal performance monitoring, particularly production of the Human Services Plans.

Methods of Carrying Out Responsibilities

To develop policy the OEHSD staff define, describe and analyze situations and recommend options for Department or state action. Examples of these activities, which support health facilities planning and health status reporting, include survey design, data systems development, data collection and data analysis. Data collected and analyzed for the IHHSR are reported from hospitals, laboratories and tumor programs.

For the certificate of need program, staff review applications for health care facility construction, acquisition of major medical equipment, substantial changes in bed capacity and initiation of new or elimination of existing services, and then recommend the IHFPB approve or deny the applications. Staff also collect and analyze hospital and long-term care facility capacity and utilization data for use in health facilities planning and certificate of need review.

Priorities

In fiscal years 1993 and 1994, the office will continue to emphasize support of assessment and policy development for the rest of the Department. Resources will be allocated for a statewide needs assessment for population-based priority setting and to assist local health jurisdictions creating community plans to improve the health status of local residents. The Illinois Public Health Surveillance System will be enhanced to assist the state and LHDs in this process.

Fiscal Year 1992 and 1993 Budgets

The appropriated fiscal year 1992 budget for the office after cuts was $2.1 million. Of this, nearly $1.2 million were General Revenue Fund and $843,000 were Illinois Health Facilities Planning Fund (IHFPF) appropriations. An additional $35,000 was appropriated from a special grant from the Public Health Foundation. The IHFPF contains fees collected from applicants for permits under the certificate of need program. When the Division of Epidemiologic Studies was transferred to the office, an additional $859,000 was allotted to the office budget, with $779,000 from the General Revenue Fund and $80,000 from the Public Health Services Fund. In addition to the appropriation, these monies were added to the office budget.

The fiscal year 1993 appropriation for the office is $2.8 million. This amount is higher than the fiscal year 1992 appropriation because it includes the budget of the Division of Epidemiologic Studies. The appropriation from the General Revenue Fund is $1.5 million, $1.2 million is from the IHFPF, and $136,000 is from the Public Health Services Fund. General Revenue Fund appropriations for the office have been reduced by more than $367,000 since fiscal year 1992.

Divisions

The office has been reorganized and now contains four divisions: Division of Health Policy, Illinois Center for Health Statistics, Division of Facilities Development, and Division of Epidemiologic Studies. Previously, the Division of Health Policy and the Illinois Center for Health Statistics were combined in the Division of Health Statistics and Policy Development and the Division of Epidemiologic Studies had been a division in the Office of Health Protection. The responsibilities of each division follow:

Division of Health Policy—To facilitate health planning and decision making through research and critical analysis of general health and health finance policy; collect, compile and analyze data on health status and health care systems; survey and assess health problems to provide the public health community effective and efficient technical assistance, program support and evaluation and monitor the financial viability of life care facilities through the administration of the Life Care Facilities Act.

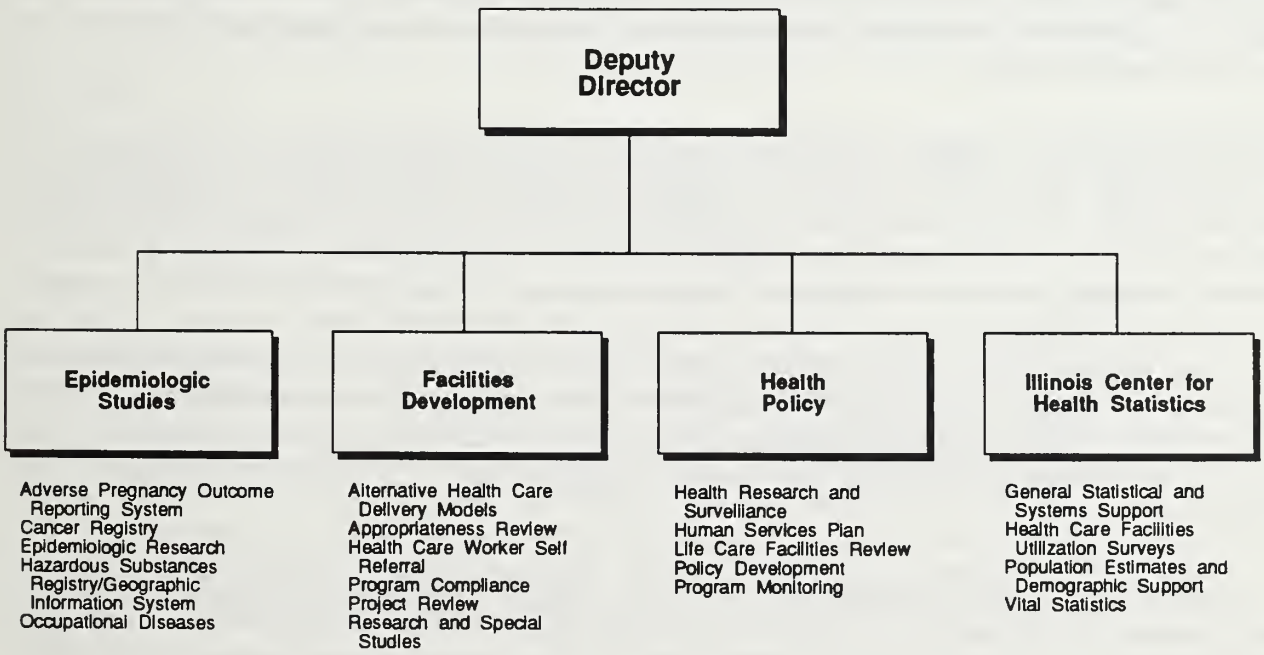
Illinois Center for Health Statistics—To ensure accurate and reliable data to assess health status and health care access are collected and accessible to support sound policy decisions through publication of the Vital Statistics annual report and annual health care facility bed inventories and administration of the population estimates program.

Division of Facilities Development—To promote access to health care, reverse the trends of increasing health care costs, and ensure appropriate investments in health care facilities occur by fulfilling the Department's obligations under the Health Facilities Planning Act and Health Care Worker Self-Referral Act through staffing the IHFPB; reviewing applications for permits under the Health Facilities Planning Act; monitoring compliance with both Acts; and developing rules for promulgation by the IHFPB.

Division of Epidemiologic Studies—In compliance with the Illinois Health and Hazardous Substances Registry Act, to collect and maintain high quality reports on the incidence of cancer, adverse pregnancy outcomes, and occupational diseases; compile data on hazardous substances relevant to possible exposures; identify potential public health problems, predict risks, evaluate public health programs and conduct cancer cluster investigations; provide information to the public and assist in public health policy formulation and Department decision making based on epidemiologic analysis.

Figure 1

Office of Epidemiology and Health Systems Development



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Program Title: **Health Policy**

Goal

To facilitate planning, decision making and policy development to improve the health status of Illinois residents.

Needs Assessment

Sociodemographic characteristics of the Illinois population such as growing African-American and Hispanic populations reflect United States trends. The rural population is diminishing in both the U.S. and Illinois, although Illinois' rural population is diminishing slightly faster than the U.S. (7.8 percent versus 5.7 percent). During the last decade, the Illinois population with incomes below 200 percent of the federal poverty level also increased, indicating a potentially larger portion of the population experiencing financial barriers to health care access. The number of uninsured persons in the U.S. is increasing rapidly and a recent Harvard Medical School report identifies Illinois as one of seven states that experienced increases in the number of uninsured of more than 100,000 persons during 1990. Unemployment and educational opportunities improved in Illinois during the 1980s, but they still remain significant problems, especially in urban areas with minority populations and in rural areas. Both rural and urban areas of Illinois, especially Chicago, continue to exhibit critical health problems and serious dysfunctions in the organization, delivery and financing of health services.

The elderly population is growing. In Illinois from 1980 to 1990, the percent of the population age 65 years and older increased from 11.0 to 12.6, and the percent of population younger than age 18 years decreased from 28.4 to 25.8. Projections anticipate more rapid growth in the size of the elderly population than that of the population as a whole through the year 2025. The effects of this population shift are clear when one considers that elderly persons as a vulnerable group demand extensive health care to meet specific needs.

The effects of infant mortality, cancer, AIDS, chronic diseases, vaccine preventable diseases, homicide and other trauma are compelling reasons for a coordinated system to provide information and analysis of health problems in Illinois to recommend effective methods of intervention. These activities and planning that focuses on the improvement of health and access to healthcare services, represent the functions of this program.

The Department is a complex organization that performs a variety of functions, including that of regulator, funder, surveyor, trainer, planner, developer and evaluator of health systems. These varied and far-reaching responsibilities have led to a need for an internal group of policy analysts who are generalists, with special expertise in policy research and financial analysis. Policy development encompasses research and analysis as well as technical support for Department programs. The target population for the Health Policy program is ultimately all the residents of Illinois, with key policy decision makers on both the state and local levels the immediate users of the program's products.

Program Activities

General Overview

The program is housed in the Division of Health Policy within the Office of Epidemiology and Health Systems Development. To achieve the goal of the Health Policy program the division conducts research and analyzes information on health status and healthcare systems, conducts needs assessments and maintains surveillance of health problems. This division was created in fiscal year 1993 by dividing the Division of Health Statistics and Policy Development into two separate entities: the Illinois Center for Health Statistics (ICHS), described in the following section of this chapter, and the Division of Health Policy (DHP). DHP encompasses three functional areas: policy development, planning and research and surveillance. The activities for each of these areas is done by one of the three sections of DHP. Descriptions of each section follow.

The ***Policy Section*** conducts policy research and analysis, including financial analysis, and facilitates consensus-building regarding developing issues. Products are primarily developed in response to the General Assembly and Director's initiatives. Activities involve literature review, assembly of background information or baseline data, preparation of issue papers, negotiation with concerned parties and preparation of recommended actions. In fiscal year 1992, policy staff provided support to the Acute Care Task Force, charged to study and formulate public policy regarding alternative healthcare delivery systems designed to meet changing health care demands. Policy staff also collaborated with the Division of Family Health to staff the Child Health Insurance Study Steering Committee to successfully develop a statewide child health insurance plan for underserved children.

Additionally in fiscal year 1992, the Policy Section refined the administration of the Life Care Facilities Act to further monitor the financial viability of life care facilities. Under this law, providers must obtain a permit from the Department prior to entering into life care contracts with individuals and must submit annual financial reports to the Department.

Staff also provide technical assistance to the Office of the Governor and the Bureau of the Budget to develop cost analyses and generate related publications. During fiscal year 1992, the section produced a primer on health care cost control for the governor's cabinet. Staff represent the Department on interagency policy groups and initiate such groups as appropriate to build consensus on policy matters (see "**Interagency Cooperation,**" p. 128).

The ***Planning Section's*** chief functions are to develop the Human Services Plan, monitor progress in achieving *Healthy People 2000* objectives and monitor program performance. In addition, staff are major contributors to policy projects such as the Acute Care Task Force.

The ***Research and Surveillance Section's*** primary functions have been to provide researchers, other Department staff and local health department (LHD) staff with technical assistance and develop and maintain an automated data retrieval system, the Illinois Public Health Surveillance System (IPHSS). The purpose of IPHSS is to make data more easily accessible for use in statistical analysis and epidemiologic studies that are required for planning and evaluating public health programs. After initial development of the data base, maintenance of IPHSS was transferred to ICHS in fiscal year 1992 because of budget cutbacks and vacancies within DHP. Additional development of the system that include the integration of hospital discharge data remained in the division and surveillance staff continued to provide consultation and technical assistance in the appropriate use of IPHSS and other data sets. In fiscal year 1993, the primary responsibility for continuing the development of IPHSS also was transferred to ICHS because of further cutbacks in DHP personnel.

Program Data

The workload for the program remained constant or increased over the last several fiscal years. The following is a description of the effect recent staff reductions—imposed by budget restrictions—have had on total productivity as reflected under "Activity Measures" in Table 1.

Table 1

HEALTH POLICY

Target Population, Recipients and Activity Measures

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
TARGET POPULATION[1]	11,431	11,543	11,552	11,560	11,569	11,857
RECIPIENTS[1]	11,431	11,543	11,552	11,560	11,569	11,857
ACTIVITY MEASURES						
Health surveillance projects:						
health statistics	15	15	15	0	0	0
special policy	47	49	54	50	50	50
Data information requests	1,500	1,500	20	200	200	200
Consults and technical assistance	200	200	185	20	20	20
Life care facilities reviews:						
permit applications	11	20	5	5	5	5
annual financial statements[2]	0	5	15	12	12	12

1. Count in thousands.
2. The reviews of life care facilities' financial reports were initiated subsequent to adoption of the Life Care Facilities Contract Code on November 21, 1990.

Health surveillance projects are analytical projects conducted upon request. These special studies, e.g., selected program evaluations, and information requests for data and sources of data have been managed primarily by the Research and Surveillance Section. Due to reduced staffing levels, this activity was suspended during fiscal year 1993.

The number of completed ***Data information requests,*** e.g., detailed vital statistics reports by local community areas, decreased significantly in fiscal year 1992 due to staff reductions and reassignments. During fiscal year 1993, this responsibility was assigned to contractual staff and other division and office staff to ensure that each LHD would receive all the specific data required for its implementation of Illinois Project for Local Assessment of Needs (IPLAN; see discussion of IPLAN under "**Program Effectiveness**," p. 127). As a result, the division should be able to complete a tenfold increase in the number of IPLAN-related requests it expects to receive from LHDs starting in fiscal year 1993.

Consults and technical assistance represent responses by the Research and Surveillance Section to requests for collection, statistical analysis and interpretation of data; by the Policy Section to requests for interpretation of the Life Care Facilities Act and rules and by the Policy and Planning Section to requests for assistance in health policy analysis. During fiscal year 1993, the numbers of responses began to decline as shown on Table 1.

Life care facilities reviews: permit applications have not been affected by staff reductions. The numbers of reviews conducted during fiscal years 1990 through 1992 reflect the numbers of applications received during those years. Staff expect the annual number of future permit applications for new facilities will be fewer than six.

Life care facilities reviews: annual financial statements have been affected by competing division priorities. Existing facilities are required to submit financial statements to the Department each year. Instead of reviewing annual reports for all facilities each year, these optional reviews will be conducted on a limited basis.

Program Effectiveness

The effectiveness of policy development—the provision of meaningful policy analysis used by Department decision makers—is difficult to quantify. A measure of effectiveness is the quantity and importance of the special policy projects conducted during the last several years. The following paragraphs demonstrate the continuing trend of the division's effective collaboration within and outside of the Department.

Notable recent successes include the division's collaboration with other divisions throughout the agency in support of the work of the Acute Care Task Force (ACTF). Specifically, division staff compiled information and prepared issue papers on alternative healthcare settings under consideration by the ACTF, provided general coordination and support to the Chair of the Task Force and prepared the Task Force's Final Report to the General Assembly. Although the recommended models were not accepted, the work of the Task Force provided the foundation for passage of the model Alternative Health Care Delivery Act, designed to undertake controlled pilot studies of alternative healthcare models in Illinois.

Another example of effective collaboration to facilitate policy formation was the division's work with the Division of Family Health and other state agencies and entities to develop a strategy and cost alternatives for a child health insurance plan for Illinois children. The results of this work were also presented to the General Assembly for consideration during fiscal year 1992.

The division contributed to the Project Health Needs Assessment Subcommittee. Staff investigated the viability of proposed needs assessment indicators by conducting a pilot study for Kankakee County and then a statewide needs assessment. This effort has extended to the initiation of IPLAN, a collaborative effort with the Center for Health Statistics, Division of Epidemiologic Studies, Office of Community Health and Office of Finance and Administration. This Project is designed to give local health jurisdictions training in and technical assistance for the data and systems development and evaluation that is required to conduct community needs assessments and develop community plans. The Project features development of data sets for each LHD, comparing area indicators with state and national data and *Healthy People 2000* objectives when available; enhancement of IPHSS for updated and additional data and assisting LHDs in building constituencies within their communities to identify and address public health issues. This process will ultimately result in the identification of new priority health problems and more effectively focus expenditure of the state's resources devoted to improving the health status of Illinois residents.

Program Objectives

The outcome objective of the Health Policy program is to integrate planning, policy analysis and surveillance functions into an effective mechanism to facilitate state and local needs assessment, monitor progress in achieving *Healthy People 2000* national health objectives and develop innovative policy options to improve the public's health and access to health care in Illinois. Specific objectives for the period covered by this report follow.

Outcome Objectives

- Conduct special studies related to health policy and perform economic and financial analyses of current health topics to improve access and quality of health care and healthcare systems by June 30, 1994
- Complete *Statewide Health Needs Assessment: Towards a Healthy Illinois 2000*, submit for public comment by February 1993, and the State Board of Health will adopt
- Assist and train LHDs to conduct community needs assessments and LHDs to submit plans to the Department by June 30, 1994
- Publish 1992–1994 Human Services Plan and submit to the General Assembly by July 1, 1993

Process Objectives

- Establish a database to streamline and support the administration of the Life Care program in Illinois by February 1993

- Establish a database to streamline and support the periodic review of financial viability of life care facilities within Illinois by June 1993
- Identify alternate sources of funding to carry out special health policy and finance data development and analyses to support planning and decision making by June 1993

Assurances

Interagency Cooperation

This program seeks to foster interagency cooperation and coordination in all projects. Staff represent the Department in numerous interagency efforts that have involved representative from some or all of the following:

American College of Obstetricians and Gynecologists
Blue Cross/Blue Shield of Illinois
Illinois Academy of Family Physicians
Illinois Department of Alcoholism and Substance Abuse
Illinois Department of Children and Family Services
Illinois Department of Insurance
Illinois Department of Mental Health and Developmental Disabilities
Illinois Department of Public Aid
Illinois Department of Rehabilitation Services
Illinois Life Insurance Council
Illinois Primary Health Care Association
Illinois State Medical Society
University of Illinois at Chicago, Division of Specialized Care for Children
Voices for Illinois Children

Family Impact

By providing research and analysis to support rational health planning, decision making and policy development, the program seeks to improve access to care and health status of the population, thereby promoting family well-being. For example, the program has collaborated with representatives of most of the agencies listed in "**Interagency Cooperation** (see above)" to develop a strategy and cost estimates for implementing a health insurance plan for Illinois children. Other program activities that specifically impact families include participation on interdepartmental groups such as the Department of Children and Family Services' Homeless Youth Subcommittee and the Illinois Assistive Technology Project (IATP) State Agency Subcommittee. (IATP is a consumer responsive program funded through federal and state resources that provides people with disabilities the adaptive tools and devices that enables them to perform everyday tasks more effectively and efficiently.)

Recommended Changes to Program

During fiscal year 1993, a major focus of the program has been the assessment and policy development function. This effort has focused on providing training and technical assistance to LHDs to facilitate their assessment of local health needs, monitoring of progress towards achieving *Healthy People 2000* objectives and development of community plans to meet identified needs. The division recommends that during the next stage of IPLAN, the Department provide assistance to LHDs for ongoing health problem analysis and implementing community plans.

Legal Citations

Illinois Welfare and Rehabilitation Services Planning Act, 20 ILCS 10/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 127, ¶ 951 *et seq.*)

Life Care Facilities Act, 210 ILCS 40/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 4160 *et seq.*)

5E_B_POL_HSP

Program Title: **Illinois Center for Health Statistics**

Goal

To provide accurate, reliable and timely health-related data and analyses required to formulate policy and implement programs in diverse health-related areas at federal, state, county and community levels.

Needs Assessment

Sound policy decisions and effective programs that address current or potential health problems require accurate, timely and reliable health-related data. Illinois policymakers and program managers need the most recent and prior census information and future population estimates and projections; natality, mortality and nuptiality figures and health status information for populations by specified geographic regions. Usually this data must be provided by gender and age, racial and ethnic groups. Policymakers and program managers also require data on the service, financial and physical profiles of licensed and certified health care facilities and programs. Sometimes they seek help with research methodology, data collection design, statistical analysis, data presentation and other techniques and skills related to formulating health policy, program management and evaluation.

Increasing demands for health-related data collection, evaluation, presentation and technical help require sufficient numbers of highly skilled professionals to expand current data systems, develop and maintain new ones and provide the technical services requested by researchers, policymakers and program managers in the public health field.

Program Activities

General Overview

The Illinois Center for Health Statistics (ICHS) is a division of the Office of Epidemiology and Health Systems Development. This division was created in fiscal year 1993 by dividing the former Division of Health Statistics and Policy Development into two separate entities: ICHS and the Division of Health Policy, described in the preceding section of this chapter.

ICHS collects, stores, generates and distributes health statistics and health facilities information to federal, county, community, private and other state agencies. Each year ICHS staff respond to thousands of requests for research data, consultations and health status and health systems reports. ICHS is the Department's liaison with federal and other state agencies in matters related to health data. ICHS encompasses two functional areas: health systems and vital statistics and demography. Brief descriptions of these areas follow.

Health Systems—Staff collect information from the Annual Hospital Questionnaire, Annual Hospital Bed Inventory Survey and Annual Long-Term Care Survey. This information includes data on admissions, clinical services, equipment, laboratory tests, live births, number of surgeries and patients days. It is a source for several detailed reports on hospitals and long-term care facilities. The most prominent of these reports is the annual Illinois Health Facilities Planning Board Inventory of Health Care Facilities and Need Determinations. The Health Facilities Planning Board refers to this report when making determinations on the need for an applicant's proposed service or facility in a specific geographic area (see "**Facilities Planning and Development**," the next program description in this chapter, pp. 132–135).

Vital Statistics and Demography—Staff use a comprehensive array of data and information from a variety of media to produce reports and fulfill requests for information. A key demographic function of this area is to represent Illinois on the Federal-State Cooperative for Population Estimates, a cooperative program with the U.S. Bureau of the Census. The most visible product is the annual Vital Statistics Illinois publication.

ICHS staff contribute population estimates and selected decennial census data for another prominent publication, the Department's Health Report Series, which focuses on health research and evaluation.

Staff maintain several databases. One of these is the Illinois Public Health Surveillance System (IPHSS). IPHSS is a relational database that integrates a variety of health-related data and creates statistical reports easily and quickly. The database is also available on disk. IPHSS includes data by specific communities and hospitals and by gender and age, race and ethnic groups. This information is used by state health program administrators, local health departments and university researchers.

Program Data

The ICHS workload increased in recent years requiring staff assignments to expand existing databases or develop and maintain new ones. Because of these reassignments and recent staff reductions, the number of ICHS projects completed has decreased (Table 1).

Table 1

ILLINOIS CENTER FOR HEALTH STATISTICS

Activity Measures

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
ACTIVITY MEASURES						
Health statistics projects	35	44	41	40	40	40
Data information requests	2,200	2,300	2,350	2,400	2,400	2,400
Consultations and technical assistance	150	150	175	175	175	175
Surveys and questionnaires entered in databases	1,313	1,320	1,336	1,720	1,800	1,800

Health statistics projects consist of analytical tasks completed by ICHS staff, including those that are part of the Illinois Health Report Series, e.g., 1990 Census Population Data for Illinois Counties and Incorporated Places; 1988–1989 Report on Long-Term Care Facilities and Illinois Hospitals 1986–1988 published in fiscal year 1992. The completion of other tasks generated Vital Statistics Illinois, 1989 and Catalog of Publications 1992, which are not part of the series.

Data information requests include requests for census, vital statistics, annual facilities survey and other data and sources of data.

Consultations and technical assistance involve requests for assistance in research design and collection, interpreting and statistical analysis of data.

Surveys and questionnaires entered in databases include annual data collected from hospitals, long-term care facilities, home health agencies, end-stage renal disease dialysis units and other healthcare facilities, clinics and services.

Program Effectiveness

The effectiveness of ICHS depends upon the accuracy, reliability and timeliness of the data produced and the quality of data analysis and other technical help provided. Staff continue to improve on the timeliness of the reports through increased computerization that expedites data entry and increases accessibility to data. An example is the current effort to set up databases to store information from the annual hospital and long-term care facility surveys. New questions were added and existing questions were revised to clarify the information being sought. ICHS staff began the process of moving the storage of the survey information from a mainframe to a personal computer to make data entry more timely, the storage and retrieval less costly, and significantly increasing accessibility for all Department staff.

ICHS staff also continually improve the more visible products of their work. An example is the continuing addition of significant data and improved layout of the Vital Statistics Illinois publication and the expansion of the Catalog of Publications. Staff are working on projects that will improve the quality of research and data analysis conducted by staff within the division and the Department.

Assurances

Interagency Cooperation

ICHS is involved in cooperative efforts with the departments of Alcohol and Substance Abuse, Mental Health and Developmental Disabilities, Public Aid, Illinois Health Care Cost Containment Council to exchange of information. ICHS staff participated in an interagency effort to get a grant to develop and implement uniform codes and data sharing that would be used by Illinois human service agencies. Although this effort did not result in getting the grant, this interagency group submitted its recommendations for interagency uniform codes to the governor in fiscal year 1993.

Family Impact

The program indirectly supports the health and well-being of Illinois families by providing accurate, reliable and timely information and analyses to federal, state, county and local researchers, policymakers and program managers who use the data to improve the quality, access and availability of public health services.

Recommended Changes to Program

The following are recommendations for ICHS:

- promote the expanded use of IPHSS, 1990 Census and vital statistics data by providing state and local health agencies with baseline statistics from these sources required for their health needs assessment
- improve IPHSS as a data system to monitor progress toward achieving *Healthy People 2000* objectives with more information, e.g., additional categories for cause of death
- promote greater intraagency use of Illinois Health Care Cost Containment Council database information by making it easily accessible for Department staff and other users
- develop and maintain databases for ambulatory surgical treatment centers, home health care agencies and hospice care services that provide for timely and cost-effective entry, storage and retrieval of data that are easy to use
- develop and maintain comprehensive profiles on equipment and usage of therapeutic radiology and magnetic resonance imaging facilities
- implement time and cost-savings automated procedures for the processing of surveys, e.g., such as scanning in completed survey forms, moving information from mainframes to personal computers
- modify data sets to include standardized coding to expedite the exchange of information with other state agencies
- review proposed International Classification of Diseases, 10th Edition changes to determine what corresponding classification and coding adjustments for statistical purposes may be needed for information collected by ICHS to assure reliability of vital statistics data comparisons

Legal Citations

Illinois Health Facilities Planning Act, 20 ILCS 3960/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 1151 *et seq.*)

Illinois Health Statistics Act, 410 ILCS 520/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 5601 *et seq.*)

5E_C_STA.HSP

Program Title: **Facilities Planning and Development**

Goal

To ensure that all residents of Illinois can access affordable healthcare services.

Needs Assessment

The high cost of medical care is associated with excess, i.e., the introduction and use of facilities, equipment, technology and treatments in areas where the need does not support their use. But the high cost of medical care is also associated with the lack of healthcare professionals, facilities, equipment, technology and treatments. When routine and preventive health care is not available or accessible, individuals tend to be seen in advance stages of conditions or diseases when their care becomes more costly. All these costs are ultimately borne by the healthcare consumer.

To promote lower medical costs, public health programs must include an oversight component to deal with these issues. The goals of this oversight component should be to promote a comprehensive healthcare delivery system. This system should assure the availability of and accessibility to quality health care by the appropriate distribution of services, facilities and equipment throughout the target population. It should prevent unnecessary construction, modification and use of healthcare facilities, equipment or services.

The 78th Illinois General Assembly passed the Illinois Health Facilities Planning Act, effective August 27, 1974. This legislation established the Illinois Health Facilities Planning Board (IHFPB). The act authorizes IHFPB to review applications and issue permits for construction, modification and establishment of healthcare facilities and the acquisition of major medical equipment. The 87th Illinois General Assembly passed the Health Care Worker Self-Referral Act applicable to referrals for health services made after January 1, 1993. This act specifies allowed and disallowed conditions of healthcare investments and referrals by healthcare workers. It also sanctions disciplinary action by the appropriate board or committee and civil penalties of no more than $20,000 for each occurrence.

The Facilities Planning and Development Program works with IHFPB to contain healthcare costs. The program promotes the development of and access to the appropriate distribution of healthcare facilities and services. It focuses on preventing unnecessary construction or modification of healthcare facilities, equipment and services. In addition, the program supports the development of a comprehensive healthcare delivery system that will assure the availability of quality healthcare facilities and related services. The target population is all Illinois residents.

Program Activities

General Overview

The Facilities Planning and Development (FPD) program is administered by the Division of Facilities Development within the Office of Epidemiology and Health Systems Development. FPD responsibilities include implementation of the Illinois Health Facilities Planning Act encompassing the certificate of need (CON), facilities planning and appropriations review, and healthcare worker self-referral (HSW). Brief descriptions of these areas follow.

CON—The Division of Facilities Development has principle responsibility for the administration of the CON program. In this capacity, the division establishes plans, policies and procedures to increase the availability of quality health care facilities and related services to the general public while containing health care costs by limiting unnecessary duplication of facilities and services.

The division also reviews and makes recommendations to the IHFPB on certificate of need applications and assesses the need for various health care services and facilities on a geographic basis. Analyses of need are performed through certificate of need reviews of proposed capital expenditures and new institutional health services.

Processing and review of certificate of need applications, in addition to specific activities, include developing standards and criteria for the review of proposed construction or modification projects, evaluating financial and economic feasibility of proposed projects and coordinating certificate of need activities with other organizations.

Other activities include monitoring the status of approved projects, enforcing compliance with provisions of the Illinois Health Facilities Planning Act regarding submission of applications, assuring the applicants fulfill the conditions of permits granted, participating in administrative hearings regarding contested cases, and providing direct administrative and staff support for the IHFPB. In addition, technical assistance is provided to potential applicants and other interested parties.

During fiscal years 1993 and 1994, staff will assist the IHFPB in the development of procedures and criteria to implement the Alternative Health Care Delivery Act and to review certificate of need applications for 13 demonstration programs for subacute care hospital models. The IHFPB expects to receive the first applications during fiscal year 1995.

HWS—Staff helped the IHFPB with the implementation of the Health Care Worker Self-Referral Act during calendar year 1992.

Program Data

Table 1

FACILITIES PLANNING AND DEVELOPMENT

Activity Measures

	Actual FY90	Actual FY91	Actual FY92	Actual FY93	Estimated FY94	Projected FY2000
ACTIVITY MEASURES						
Applications reviewed	186	175	145	200	200	200
Compliance reviews completed	440	416	412	400	500	500
Technical assistance provided	500	633	574	700	700	700

During 1992 the division completed special reports for IHFPB that were requested by the General Assembly. These reports, which used significant amounts of staff time, were: Study of Illinois Hospital Capital Expenditures pursuant to House Resolution 450 and Study of Illinois Health Care Facilities Standards pursuant to Senate Resolution 571.

The number of certificate of need applications reviewed during fiscal year 1993 was nearly 40 percent more than during fiscal year 1992.

Since HWS recently became effect effective January 1, 1993, meaningful program data is not available at this time.

Program Effectiveness

General

Because CON and HWS activities have a significant sentinel effect, i.e., their existence discourages facilities and individuals from even applying for permits for imprudent projects or inappropriately investing in health facilities, measuring their effectiveness is difficult. However, one way of measuring the effectiveness of CON activities is comparing the number of proposed projects undertaken that answer the unmet needs of a community and are financially and economically feasible and the number of proposed projects that do not meet those conditions and are not undertaken with the total number of proposed projects.

A limited evaluation of effectiveness can be made by comparing the original costs of proposed projects with the actual permit amounts approved by the IHFPB. Only proposed costs that conform with prescribed standards and criteria should be approved as "needed." While all proposed expenditures should meet the standards of need, dollar expenditures approved which are below 100 percent of proposed dollars indicate that unnecessary expenditures have been eliminated or disallowed by IHFPB (Table 2).

In addition, the extent to which the development of facilities and services is consistent with plans of need is an indicator of accessibility to health care facilities and services. An example is the conversion of unutilized excess medical-surgical beds to meet the demand for nursing care beds.

Table 2

FACILITIES PLANNING AND DEVELOPMENT

Outcome Objectives and Actual Performance

	Actual FY90	Actual FY91	Actual FY92	Actual FY93	Estimated FY94	Projected FY2000
Proposed costs that conform with prescribed standards and criteria[1]						
process objective	90	90	90	90	90	90
actual performance	92	89	79	93	NA	NA
Acute care bed need met[1]						
process objective	100	100	100	100	100	100
actual performance	147	142	149	150	NA	NA
Nursing care bed need met[1]						
process objective	100	100	100	100	100	100
actual performance	108	107	105	105	NA	NA

1. Percent.

Assurances

Interagency Cooperation

As previously indicated, Facilities Planning and Development staff support and work with (i.e., staff) the IHFPB. The Departments of Public Aid and Mental Health and Developmental Disabilities each hold an ex-officio seat on the IHFPB.

Family Impact

The program supports the health and economic well-being of Illinois families through activities that promote a statewide comprehensive healthcare delivery system that is accessible, available and contains capital costs.

Recommended Changes to Program

The division should review and revise existing standards, criteria and assessments of need during fiscal year 1994. It should also submit recommendations to the Illinois General Assembly that would implement statutory changes consistent with the repeal of the federal National Health Planning and Resources Development Act and modify Illinois Health Facilities Planning Act with provisions for enforcing program compliance.

Legal Citations

Alternative Health Care Delivery Act, 210 ILCS 3/1 *et. seq.*

Health Care Worker Self-Referral Act, 225 ILCS 47/1

Illinois Health Facilities Planning Act, 20 ILCS 3960/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 1151 *et seq.*)

5E_D_FPD.HSP

Program Title: **Epidemiologic Studies**

Goal

In compliance with the Illinois Health and Hazardous Substances Registry Act, to collect and maintain high quality reports on the incidence of cancer, adverse pregnancy outcomes and occupational diseases; to compile data on hazardous substances relevant to possible exposures and to monitor these health outcomes in order to detect potential public health problems, predict risks, evaluate public health programs and conduct cancer cluster investigations, and to provide information to the public and assist in public health policy formulation.

Needs Assessment

Epidemiology is defined as the systematic, objective study of diseases within populations and the factors that determine their distribution. It is the common scientific foundation for the myriad professional disciplines in public health. Public health professionals use the epidemiologic approach and their technical knowledge to understand the causes of disease, identify populations at risk and develop health promotion strategies (IOM, *Future of Public Health*, pp. 40–41).

In Illinois the primary resource for this approach is IHHSR which is an umbrella registry that includes four component registries: the Adult Blood Lead Registry (ABLR), the Adverse Pregnancy Outcomes Reporting System (APORS), the Hazardous Substances Registry (HSR) and the Illinois State Cancer Registry (ISCR). Brief descriptions of the health concerns related to each of these registries follow.

ABLR—Lead exposure can produce a variety of cardiovascular, hematologic, metabolic, neurotoxic and reproductive effects. Maternal lead exposure is associated with reduced birthweight, shortened gestation and impaired neurological development in infants and young children. Each year ABLR receives reports on 2,200 cases of adults with elevated blood lead levels.

APORS—Adverse pregnancy outcomes often result in infant mortality and contribute to childhood mortality and long-term disability. The Department created APORS to guide public health policy in the reduction of adverse pregnancy outcomes and to identify and track children who require special services in order to correct or prevent developmental problems and other disabling conditions. APORS data can be used to identify associations between specific causes of infant mortality and risk factors, such as maternal exposure to toxic substances. For example, the use of cocaine during the early stages of pregnancy is associated with fetal loss. During the later stages of pregnancy it induces labor, leading to premature birth.

In 1989, birth defects were responsible for nearly 400, or 24 percent of, infant deaths in Illinois. They were the major leading cause of infant deaths among whites and the second leading cause of infant deaths among blacks. Additionally, about 7,000 birth defects were diagnosed in 1989, making birth defects one of Illinois' most serious child health problems.

HSR—Linking health outcome data for Illinoisans and hazardous substances in the environment allows the division to better investigate potential relationships among them. The implementation of a geographic information system, HSR, and the geographic coding of health outcome data and potential sources of exposure to hazardous materials will make this linkage possible. The Department can identify intervention methods through epidemiologic assessments of geographic clusters of cancer, adverse pregnancy outcomes and occupational diseases associated with exposures to environmental or occupational toxicants.

ISCR—This registry provides information on the cancer incidence in the Illinois population. Currently, more than 48,000 new cases are diagnosed and reported annually. ISCR data can be used to assess the impact of cancer control and early detection programs. For example, the breast cancer incidence is increasing about 5 percent annually and, in 1990, 65 percent of Illinois breast cancer cases were diagnosed in an early stage.

The division will use ISCR data to determine progress toward the *Healthy People 2000* objective of diagnosing 80 percent of breast cancer cases in an early stage.

Program Activities

General Overview

The Epidemiologic Studies program is administered by the Division of Epidemiologic Studies within the Office of Epidemiology and Health Systems Development. The mission of the division is to collect and maintain high quality reports on cancer, adverse pregnancy outcomes and occupational diseases; conduct epidemiologic assessments on public health and hazardous substances; provide a source of information for the public; assist in the formulation of public health policy; monitor cancer incidence to detect potential public health problems, predict risks and conduct cancer cluster investigations; use cancer data to target intervention resources for communities and patients and their families; inform health professionals and citizens about risks, early detection and treatment of cancers elevated in their communities and promote high quality research to provide better information for cancer control.

To carry out this mission the division develops, maintains and improves IHHSR component registries. These databases are the only population-based source for information on the incidence of adverse pregnancy outcomes, cancer and occupational diseases. The division uses IHHSR as the primary resource to respond to requests from the public, elected officials, physicians and scientific researchers. The entire Illinois population is the target for information regarding registry data and their relationship with hazardous substances at work, at home or in the environment.

Division staff conduct epidemiologic assessments on cancer, other public health problems and hazardous substances. Staff publish some of these studies as part of the division's Epidemiologic Series Reports. They submit others to peer-reviewed scientific journals for publication. Staff also present the results of these studies at various state and national scientific meetings. In addition, research staff actively submit grant proposals to augment research funding (Table 1).

Table 1

EPIDEMIOLOGIC STUDIES

Activity Measures

	Actual FY89	Actual FY90	Actual FY91	Actual FY92	Estimated FY93
DATA REQUESTS					
General information	77	115	133	115	115
Data and reports	302	355	288	277	250
Cluster investigation	24	20	30	13	12
EPIDEMIOLOGIC STUDIES					
Reports	5	5	4	3	5
Publications	NA	NA	2	4	3
Presentations	NA	NA	9	16	10
Grant proposals funded	1	1	1	2	2
Studies -					
in progress	NA	NA	11	7	10
in press	NA	NA	1	13	5
QUALITY ASSURANCE STUDIES					
Hospital casefinding	1	1	1	2	2
Hospital reliability	1	1	0	0	1
Hospital reabstract	1	0	0	0	1
Internal quality control	5	19	11	6	10

The importance of high quality reports on adverse pregnancy outcomes, cancer and occupational diseases is reflected in the quality assurance activities done by each registry component. The protocols to optimize high quality data focus on completeness of reporting (case-finding), timeliness of reporting, accuracy of reported data (reliability and reabstract) and extent of missing case-specific data. Not only do these activities evaluate quality of data reported, they also provide a supplemental benefit of continuous training for reporting facilities (Table 1).

Program Data

Table 2

EPIDEMIOLOGIC STUDIES

Program Data Measures

	Actual 1987	Actual 1988	Actual 1989	Actual 1990	Estimated 1991
APORS cases	6,972[2]	13,284	16,238	15,272[3]	15,120
ISCR cases	48,129	48,332	48,385	49,378	49,590
Occupational disease cases					
coal workers' asbestosis	154	134	139	NA	140
coal workers' pneumoconiosis	265	217	216	NA	220
coal workers' silicosis	67	54	42	NA	40
lead poisoning	NA	9	500	1,729[4]	2,209
acute pesticide poisoning	88	119	105	NA	100
Occupational injury cases					
heavy metal poisoning	158	177	147	NA	150
crushing injury to lower arm	162	159	145	NA	150
thumb and finger amputations	607	608	631	NA	610
chemical burns to the eye	97	109	94	NA	100
Hazardous substances					
nuclear material[5]					
storage facilities	NA	8	8	8	8
human exposures	NA	0	0	0	0
transportation incidents	NA	12	8	1	2
incidents[6]	NA	1,761	2,733	3,793	3,758
complaints[6]	NA	587	414	896	861
generating companies[7]	NA	2,448	2,213	1,482	NA
generated waste, in tons[7]	NA	1,543,937	1,744,866	6,229,076	NA
TSDR[8] companies[7]	NA	329	215	152	NA
TSDR waste, in tons[7]	NA	1,819,204	2,011,678	6,412,589	NA

1. Amended numbers from earlier reports reflect newly implemented data exchange agreements for residents diagnosed out-of-state. Calendar years 1989 through 1991 counts include estimates for out-of-state cases.
2. Reporting began August 1, 1987; thus, number reflects five months of data only.
3. Case definition revised.
4. The threshold for reporting was lowered on 4/1/90 and is now based on laboratory reporting. Count is for nine months only.
5. Source: Illinois Department of Nuclear Safety, Office of Chemical Safety, Division of Inspection and Operations, December 1991.
6. Source: Illinois EPA, Office of Chemical Safety, Emergency Response Unit, March 1992.
7. Source: Illinois EPA, Division of Land Pollution Control, March 1992.
8. Treatment, storage, disposal and recovery.

APORS cases represents adverse pregnancy outcomes that must be reported to the Department. This population-based registry's target population is Illinois newborns and mothers. Currently a computerized geocoding service has coded 83 percent of the addresses of APORS cases to census tract or enumeration district level. This census coded information enables the division to respond to public inquiry regarding perceived disease clusters in small geographic areas.

Nearly 3 million female Illinois residents are of childbearing age, and in 1990, there were 195,499 registered live births. Of these, 15,272 were reported to APORS with adverse pregnancy outcomes. In 1990, the number of cases reported to APORS decreased because hospitals were no longer required to report infants with minor congenital anomalies (e.g., skin tags).

ISCR cases represents the number of cases reported to the Department on patients diagnosed at Illinois hospitals including three of eight Veteran's Administration facilities and one of three military hospitals. Additionally, exchange agreements with Iowa, Wisconsin, Indiana, Missouri and Florida provide cancer incidence data on approximately 2,000 more Illinois residents diagnosed or treated in these states.

Currently, a computerized geocoding service has coded 81 percent of the addresses of ISCR cases to census tract or enumeration district level, enabling the division to respond to public inquiry regarding perceived disease clusters in small geographic areas.

ISCR fills hospital requests for local, regional and statewide cancer information and provides a cancer database for public health epidemiologists and national and international researchers. ISCR staff maintain quality control programs to insure complete case ascertainment and reporting of accurate and valid cancer data. Each year staff conduct casefinding studies and between four and 10 internal quality control studies. They conduct biannual reliability studies and reabstracting studies once every five years.

Occupational disease cases show information on five occupation-related diseases including lead poisoning. The division uses hospital discharge data obtained from the Illinois Health Care Cost Containment Council (IHCCCC) to estimate the annual number of hospitalized cases of coal workers' asbestosis, pneumoconiosis and silicosis and poisonings due to pesticides.

The division's surveillance and intervention activities target Illinois employees, nearly 5.3 million persons. During 1989, there were 1,002 cases of occupational diseases monitored by the Occupational Disease Registry. In 1991, there were 2,709 cases. Most of this increase was due to an increase in the Adult Blood Lead Registry data, with minimal increases in the other occupational diseases.

The ***lead poisoning*** information represents cases of elevated blood lead levels of 25 mcg/dl or greater, which must be reported to the Department. The source for the number of 1988 cases of elevated adult blood levels was hospital discharge data, an underestimate, since only a small number of cases required hospitalization. During 1989, a pilot study for ABLR identified 500 cases. In April 1990, mandatory reporting began. The cases reported represents a nine-month period. The number of 1991 cases reflect more accurately the number of cases that will be reported each year in Illinois.

Occupational injury cases reflect the number of persons hospitalized for four categories of occupational injuries. The division uses IHCCCC hospital discharge data to estimate the annual number of cases of selected occupational injuries (heavy metal poisonings and crushing injury to the lower arm, thumb and finger amputations and chemical burns to the eye). During 1989, 1,017 persons were hospitalized with these four occupational injuries. Although the data are not yet available, we estimate the same number of these injuries occurred during 1991.

In fiscal year 1994, staff will use hospital records identified by IHCCCC surveillance to contact silicosis patients and identify workplace exposures that may cause silicosis in Illinois workers.

Hazardous substances information on nuclear materials shows that the number of storage sites did not change from 1988 to 1990 and the number of transportation incidents declined from eight to only one. During this same time period, the number of companies generating other hazardous wastes declined, as did the number of companies involved in the treatment, storage, disposal and recovery of hazardous waste. The amounts of hazardous waste generated or involved in treatment, storage, disposal and recovery increased by more than 300 percent.

The Hazardous Substances Registry will map adverse health outcomes and sources of environmental toxicants, including hazardous waste sites on the National Priorities List (NPL) in areas where computerized maps are available. Staff will use these maps to assess the health impact of toxic substances in Illinois and set priorities for specific epidemiologic studies.

Program Effectiveness

Quality Control

High quality data are critical to accurate interpretation of disease statistics, sound decision-making, policy development and evaluation of programs and specific objectives. The assurance of high quality registry data requires established, standardized and scientifically rigorous registry processes. Staff of each registry continuously conduct quality assurance activities that focus on completeness and accuracy of reported data to identify and immediately correct those processes that adversely affect data quality. These studies not only evaluate registry quality, but also provide continuous training and feedback for reporting facilities.

Process Objectives

To continue ensuring the high level of registry data quality and availability, the division established the following process objectives for fiscal years 1993 and 1994:

Fiscal Year 1993

- implement an independent, annual casefinding protocol for all hospitals reporting to ISCR
- complete three quality control studies of APORS cases to ensure high quality data for research in reducing infant mortality
- complete research studies on infant mortality from 1980–1989 to improve knowledge about the causes of infant mortality in Illinois
- increase participation of more local health departments (LHDs) and industries in ABLR follow-up and intervention activities

Fiscal year 1994

- establish a surveillance system that identifies silicosis cases and describes workplaces that may contribute to the development of this occupational disease
- implement geographic technology to map health outcome data and toxic release sources, especially NPL sites
- complete data analysis to measure the impact of physician interventions targeted at increasing access to state-of-the-art breast cancer management among rural Illinois women
- complete state and county reports needed for needs assessment of cancer incidence, birth defects, occupational diseases and injuries and environmental indicators

The following descriptions discuss the effectiveness by program areas:

APORS—In fiscal year 1992 the division developed a surveillance report to monitor trends of infants born with drug toxicity. Groups and other state agencies use this report, compiled quarterly, for policy development and planning for the education and treatment needs of these children. Staff identify and refer high risk infants to the Perinatal Tracking System for free follow-up visits. Local health nurses visit these infants at 6, 12 and 18 months of age. Staff report infants born with congenital syphilis to the Department's Congenital Syphilis Program and report infants with cleft lip or cleft palate to the Department's Craniofacial Anomaly Program, which provides care and resource information for early intervention and correction of this birth defect (see Chapter II, **"Oral Health"** program description, p. 50).

HSR—In collaboration with the Department's Division of Environmental Health, cancer cases and National Priority List (NPL) sites in DuPage County have been mapped by census tract. Staff use these maps to assess the proximity of the NPL sites and specific cancers associated with an exposure to the hazardous substances in the NPL sites.

ISCR—ISCR collects information on cancer cases, more than 250,000 since its inception in 1985. The division estimates that 95 percent of all Illinois cancer cases are reported to the state registry, making it the largest and only population-based, registry on cancer incidence, diagnostic stage, occupation and other cancer risk factors. This program insures that cancer incidence information for the Illinois population is available to evaluate progress toward achieving *Healthy People 2000* objectives and conduct accurate and timely needs assessments for all public health jurisdictions in the state.

Quality control programs insure that reported data are accurate. In fiscal year 1993, special quality assurance activities will focus on improving ascertainment of cancer cases in Illinois males. Case reporting from federal hospitals located within Illinois is excluded from the state's mandate; yet, these facilities provide medical care to a large number of Illinois men.

The importance of ISCR data in program development and evaluation is shown through their use in the federally funded grant, Database Intervention Research for Cancer Control in Illinois. Staff used the ISCR database to identify breast cancer cases in central Illinois for a medical record audit that identified the barriers or gaps in the receipt of state-of-the-art diagnostic and treatment procedures. Program staff designed and implemented a physician intervention based on these local data. The division will evaluate these activities, again using ISCR data, in fiscal year 1993 as the project completes its final year of a five-year program. The division submitted an application for continuing this important project to the National Institutes of Health (NIH), with funding to begin, if awarded, in late fiscal year 1993 for a proposed four-year term.

Occupational Diseases Registry—The division received two federal grants in fiscal year 1993 to support occupational disease surveillance activities mandated by the Illinois Health and Hazardous Substances Registry Act but not funded by the state. One grant supplements ABLR follow-up activities by providing follow-up for industries and localities not served by an LHD. This grant, from the National Institute for Occupational Safety and Health (NIOSH), is for three years at $27,000 per year. NIOSH also funded the second grant for silicosis surveillance and intervention. Staff will use this $50,000 grant, renewable for four years, to conduct workplace visits and identify and control exposures that may cause silicosis.

ABLR works with LHDs to identify individuals for follow-up, which includes education, counseling and referrals of family members for lead screening. LHDs participate on a voluntary basis. In fiscal year 1992, staff made several changes to improve efficiency of ABLR operations. They developed a system to track records and criteria to identify multiple reports for a single individual. Reorganization of the database reduced data entry keystrokes by more than 60 percent. The changes included computerizing all the forms used for follow-up activities.

Table 3

EPIDEMIOLOGIC STUDIES

Outcome Objectives and Actual Performance

	Actual 1989	Actual 1990	Actual 1991	Actual 1992	Estimated 1993	Projected Year 2000
Breast cancer cases diagnosed in early stage[1]						
outcome objective	NA	NA	NA	NA	NA	80
actual performance	63	65	NA	NA	NA	NA
Cervical cancer cases diagnosed in situ[1]						
outcome objective	NA	NA	NA	NA	NA	90
actual performance	77	73	NA	NA	NA	NA
Cervical cancer cases diagnosed in distant stage[1]						
outcome objective	NA	NA	NA	NA	NA	0
actual performance	2	3	NA	NA	NA	NA
Birth defects[2]						
outcome objective	NA	NA	NA	NA	NA	NA
actual performance	358	300.1	267.9	NA	NA	NA
Infants positive for cocaine[3]						
outcome objective	NA	NA	NA	NA	NA	0
actual performance	NA	NA	1,381	1,476	NA	NA
Very low birthweight infants[3]						
outcome objective	NA	NA	NA	NA	NA	1,900[4]
actual performance	2,980	2,785	NA	NA	NA	NA
Occupational lung disease[3,5]						
outcome objective	NA	NA	NA	NA	NA	250
actual performance	405	397	NA	NA	NA	NA
Generated wastes[6]						
outcome objective	NA	NA	NA	NA	NA	1,157,962
actual performance	1,744,866	6,229,076	NA	NA	NA	NA
Adult blood lead levels >25 mcg/dl[3]						
outcome objective	NA	NA	NA	NA	NA	0
actual performance	NA	1,730	2,169	2,155	NA	NA

1. Percent.
2. Per 10,000 live births.
3. Number of cases.
4. The *Healthy People 2000* goal is to lower the proportion of very low birthweight births to 1.0 percent of total live births. Illinois' goal of 1,900 is equivalent to 1 percent of average yearly births of 190,000.
5. The *Healthy People 2000* objective for occupational lung disease is the elimination of exposures that cause these diseases. Because of the long average latent periods of occupational lung diseases, the removal of these exposures between 1992 and 2000 will not eliminate the disease by 2000, but there should be a reduction in the total number of cases due to more recent exposures.
6. In tons. A *Healthy People 2000* objective for environmental health is the reduction of toxic releases by 25 percent between 1987 and 2000. If the amount of generated hazardous waste is used as a surrogate for toxic releases, then toxic releases may have been increasing since fiscal year 1988. Efforts to reduce this increase must be made by agencies with jurisdiction over the generation of hazardous waste.

Assurances

Interagency Cooperation

The division receives guidance on registry development and functions from the Health and Hazardous Substances Coordinating Council (HHSCC). The council consists of representatives from the departments of Agriculture, Energy and Natural Resources, Labor and Nuclear Safety; the Environmental Protection Agency and the School of Public Health at the University of Illinois. Examples of cooperative efforts by HHSCC participants are the street maps and environmental databases supplied by the Department of Energy and Natural Resources and the Environmental Protection Agency for use by HSR staff.

The division works closely with other divisions within the department, including Family Health, Dental Health, Infectious Diseases, Laboratories and Environmental Health. The division also cooperates with other agencies including the departments of Agriculture, Energy and Natural Resources, Labor and Nuclear Safety; the Environmental Protection Agency; IHCCCC and the Illinois State Board of Education. ABLR shares data with the Department's Childhood Lead Poisoning Prevention Program and Toxicology Program and with the Illinois Department of Labor and the federal Occupational Safety and Health Administration's regional offices, regulatory agencies that conduct worksite interventions and inspections for cases reported to ABLR. This cooperative effort helps eliminate duplication of services.

The division also cooperates in special collaborative activities and research investigations of federal agencies, e.g., the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registries. Upon request, staff share non-confidential data from all IHHSR components with national registries or databases. They also send lead data to the National Lead Registry each quarter; cancer data to the American Association of Central Cancer Registries annually and birth defect data to CDC for use in special surveillance studies.

Family Impact

The incidence of adverse pregnancy outcomes, cancer and occupational diseases directly affects families. APORS infants are eligible for follow-up visits by local health agencies and referrals to appropriate intervention services, a positive service for Illinois families. Maternal exposure to lead dust transported home on workers' clothes can result in low birthweight and mental retardation in children. Adults who have elevated blood lead levels receive information from staff that will help families avoid exposure. Occupational diseases can detract from the quality of family life by removing wage earners from the workforce and decreasing family income. The prevention of these diseases will ensure that Illinois workers remain employed and the economic status of their families remains secure. The prevention of cancer and birth defects due to toxic releases protects families from devastating medical problems and devaluation of family assets. The data collected from all IHHSR components assist with Departmental decision making and shaping policy development to prevent adverse health outcomes in families.

Recommended Changes to Program

As IHHSR continues to evolve, the division will focus on the expanded use of registry data to improve understanding of how adverse pregnancy outcomes, cancer and occupational diseases affects, differentially, Illinois' culturally diverse population.

Legal Citations

Developmental Disability Prevention Act, 410 ILCS 250/0.01 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 2100 *et seq.*)

Illinois Health and Hazardous Substances Registry Act, 410 ILCS 525/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 6701 *et seq.*)

Lead Poisoning Prevention Act, 410 ILCS 45/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 1301 *et seq.*)

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CHAPTER VI

OFFICE OF FINANCE AND ADMINISTRATION

Introduction

Mission

To provide those services and products necessary to ensure full and efficient functioning of the Department.

Summary of Responsibilities

Program Overview

An organization as large and complex as the Illinois Department of Public Health needs a broad variety of services and materials to enable employees to perform their duties. While employees bring their knowledge and skills to the Department, they require computers, supplies, telephones, lights, heat, etc., to function effectively. It is the duty of the Office of Finance and Administration (OFA) to provide these items to the Department and, in some instances, to other public health agencies in a timely, efficient and cost-effective way. In addition, because administrative services are inextricably combined with programs, some OFA staff carry out highly specialized functions, including Regional Health Officers (RHOs) who direct the Department's seven regional offices. These RHOs coordinate various agency programs at the regional level and carry administrative responsibility.

Methods of Carrying Out Responsibilities

The Office of Finance and Administration carries out its responsibilities under direction of Department directives and guidelines, legal mandates of programs administered and rules and regulations developed within OFA. The office is organized into well-defined divisions, some of which provide internal services or products only, e.g., the Division of Financial Services. By contrast, the State/Local Liaison unit enters into program management and service delivery through provision of technical assistance and consultation to local health departments (LHDs) and county boards.

Priorities

Special efforts were made in fiscal year 1993 to continue many of the important liaison and support functions of local health services that will be coordinated through the new State/Local Liaison Unit. In addition the office will complete on-line Electronic Birth Certificate (EBC) Program in Vital Records by January 1, 1995. The EBC is a personal computer-based system that enables hospitals to electronically enter birth data directly into the state's Vital Records database. At present, 55 percent of Illinois hospitals and 65 percent of all Illinois births are reported through the EBC system.

Another priority, basic to Department policy, is to have LHDs provide public health services to all areas of Illinois. Currently, 4 percent of the state's population is not covered by comprehensive public health services offered by LHDs.

Fiscal Years 1993 through 1994 Budgets

The budget for OFA provides financial support for the Office of the Director, all seven regional offices, plus the divisions of Electronic Data Processing, Financial Services, Personnel and Business Services, and Vital Records; the State/Local Liaison Unit; the Training Center; Employee Services; and the Word Processing Center. In addition, most commonly used Department supplies, paper, printing needs and shared equipment, such as copiers and vehicles, are purchased through funds appropriated to OFA.

In fiscal year 1993 the Department is providing support to 86 LHDs through Basic Health Services and Developmental Grants. In 1994, the Basic Health Services Grant was renamed the Local Health Protection Grant.

The Social Security Enumeration Project and the Electronic Birth Certificate Program are supported by funds from the Department of Health and Human Services and Illinois General Revenue Fund. The Department's participation in the Illinois State Enforcement Agencies to Recover Children (I-SEARCH) Program is funded through General Revenue Funds.

Divisions

The office has been reorganized and now contains four divisions: Division of Electronic Data Processing, Division of Financial Services, Division of Personnel and Business Services and Division of Vital Records. During fiscal year 1992, the Division of Personnel and Business Services was formed by merging the Division of General Services and the Division of Personnel and Labor Relations. During fiscal year 1993, the Division of Local Health Administration was downsized into the State/Local Liaison Unit with many responsibilities being shared with or reassigned to other components within OFA and other offices of the Department. The responsibilities of each division follows:

Electronic Data Processing—To develop cost-effective data processing solutions to meet the information and data needs of the Department.

Financial Services—To provide fiscal support for all programs within the Department by obtaining resources required to carry out the delivery of public health programs and services; to report the use of fiscal resources that support these programs and to perform day-to-day financial and administrative transactions in accord with applicable state and federal guidelines.

Personnel and Business Services—To provide comprehensive personnel services consisting of planning, directing and administering a total complement of personnel programs and policies, including management advice and counsel, position classification actions, personnel transaction processing, insurance benefits processing, administration of collective bargaining agreements and agency timekeeping.

The Business Services Section plans, designs, implements and monitors procedures in the Department for real estate leasing and management; inventory and supply control and obtaining adequate telecommunications, vehicles, printing, mail and other utilities.

The Employee Services Unit provides a variety of benefits to state employees. Many of these benefits are designed to provide security to employees' families, assist with family responsibilities and help prepare staff for a secure future. Programs included in this unit are the Deferred Compensation Pay Plan; life, dental, health and long-term care insurance; retirement benefits and savings programs; the worker's compensation program and unemployment insurance program. In addition, this unit coordinates the Savings Bond Program, Dependent Care Program and Medical Care Assistance Program.

The Employee Assistance Program provides confidential assistance to employees or members of their immediate family when their job performance or behavior declines due to personal problems stemming from alcohol or substance abuse, emotional or medical difficulties, or financial or legal problems.

Vital Records—To manage and maintain a statewide vital records registration system including, but not limited to, the registering, amending and certifying the records of all births, deaths, marriages and divorces occurring in Illinois.

In addition to the four divisions there are four components that provide significant support services to the Department or LHDs. The responsibilities of those components follow:

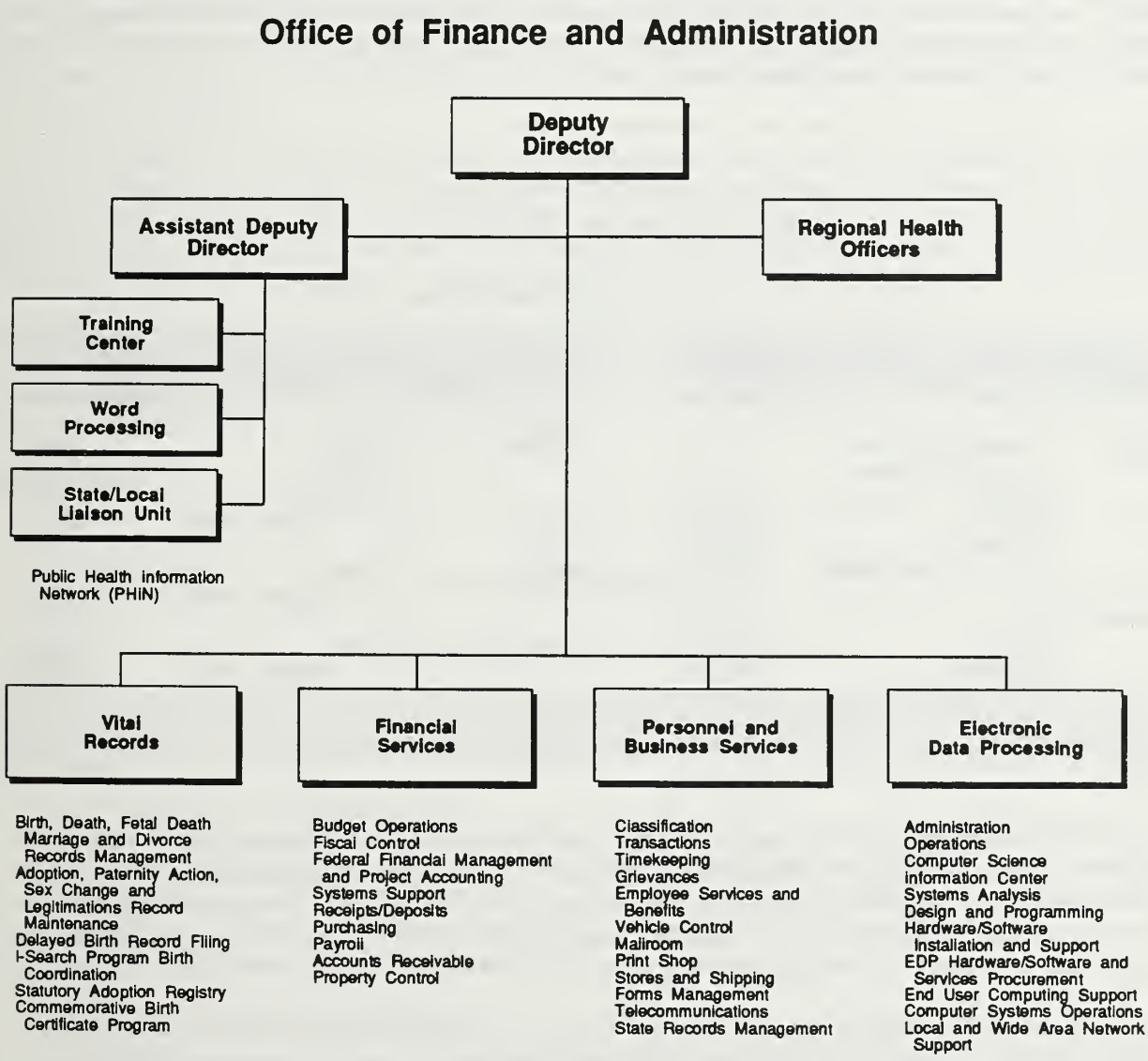
Regional Health Officers—To provide administrative support to the Department's seven regional offices. The RHOs coordinate various agency program activities at the regional level, including: scheduling of surveys and inspection activities, initiating requests for enforcement and compliance actions and serving as liaison with local health agencies and associations.

State/Local Liaison—To provide technical assistance to LHDs that ensures quality public health services to all Illinois residents.

Training Center—To promote the personal and professional development of employees, helping them to sustain excellent performance, be highly motivated, get along well with their fellow workers and understand their role in carrying out the Department's responsibilities. To accomplish its mission, the center assesses the need for training, provides learning materials for employees through orientation, clerical, supervisory and management training and promotes opportunities sponsored by other organizations.

Word Processing—To provide all Department offices with word processing support.

Figure 1



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Program Title: **Local Health Services**

Goal

To ensure that basic public health services are available to all residents of Illinois.

Needs Assessment

State and national public health authorities agree that public health services, which improve the health and environment of residents, are best and most efficiently delivered at the local level. Yet nearly 513,000 Illinois residents in 12 counties do not have comprehensive public health services available. Most of those 12 counties are predominantly rural; two have both rural and urban areas. Of those two counties, one (Champaign) has a local health department (LHD) serving the central, urban area but not the rural areas. The unserved Illinois counties are listed below (Table 1).

Table 1

LOCAL HEALTH SERVICES

Counties Not Served by Local Health Departments[1]

IDPH Region	County	Population Not Served	IDPH Region	County	Population Not Served
Champaign	Champaign (outside Champaign-Urbana)	73,179	**Marion**	Edwards	7,440
	Clark	15,921		Marion	41,561
	Edgar	19,595		Richland	16,545
	Moultrie	13,930		**Region Total**	**65,546**
	Region Total	**122,625**	**Peoria**	Warren	19,181
Edwardsville	Scott	5,644		**Region Total**	**19,181**
	Clinton	33,944	**Rockford**	Carroll	16,805
	Madison	249,238		**Region Total**	**16,805**
	Region Total	**288,826**		**TOTAL**	**512,983**

1. As of January 1, 1993.

The Department does not have sufficient staff to meet all of the service needs of the uncovered local areas. A commitment of resources to provide such direct services would draw resources from the Department's roles of technical assistance, consultation, education and training to establish LHDs. Thus, the Department has made a strong commitment both to encourage the establishment of LHDs statewide and to support the expansion of the programs in all existing LHDs to ensure the delivery of quality public health programs.

Existing LHDs need both technical and financial assistance to ensure provision of a full range of quality public health services. Significant progress has been made in the past 10 years in the number of LHDs that have received Department approval of 10 basic health programs: administration, child health, chronic disease, communicable disease control, food sanitation, maternal health and family planning, nuisance control, potable water, private sewage disposal and solid waste. This approval is required for LHDs to receive maximum Department funding from the Basic Health Services Grant (BHSG) allocation. In fiscal year 1992, 75 LHDs

received approval for all required programs. In fiscal year 1994, LHDs will no longer be required to provide 10 basic health programs for certification. Instead LHDs must conduct community needs assessments and prepare community plans to comply with certification.

Two issues are of critical importance when considering local health service activities in the future: 1) the Department's priority for LHDs to provide basic public health services in all areas of the state and 2) the consolidation or sharing of services among new and existing LHDs. Established LHDs are experiencing an unprecedented demand for services and, in many cases, are struggling to find the financial resources to support these services. Adequate funding must be made available through federal, state and local resources.

Program Activities

General Overview

The State/Local Liaison Unit administers the Local Health Services program, which targets all residents of Illinois who may use public health services. However, recipients of direct services from this program are existing LHDs and individuals or organizations in counties with no health departments. A diverse array of services is provided under the umbrella program title of "local health services." These services include promoting and assisting the development of LHDs; providing fiscal and programmatic support to existing LHDs; and maintaining the Public Health Information Network with LHDs to expedite the transmission of information via computer.

In areas of Illinois without basic public health services, the Department helps local organizations or groups interested in developing an LHD. In some areas, it is necessary to seek out such groups and educate their members on the importance and role of an LHD. This is a long-term activity which, in some areas, may be repeated over many years to bring success. The Department provides financial incentives to assist new health departments with start-up costs.

Established health departments receive assistance with basic operating expenses through the distribution of the BHSG funds. Unlike other Department grants, BHSG funds are noncategorical and, thus, may be used to support activities determined to be priorities by each LHD. In fiscal year 1992, the appropriation for the BHSG was $8,831,000 or 77 cents per resident served.

Program Data

Table 2

LOCAL HEALTH SERVICES

Recipients and Activity Measures

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
RECIPIENTS						
Counties without local public health services	16	16	13	11	10	0
Counties developing local health services	5	5	6	6	5	0
Counties with local health departments (LHDs) receiving BHSG funds	76	76	78	80	82	97
ACTIVITY MEASURES						
New LHDs	3	0	3	2	2	0
Consultations with developmental LHDs						
on-site	19	20	15	10	10	0
telephone	105	135	125	60	60	0
Consultations with established LHDs						
on-site	67	77	90	50	50	97
telephone	1,135	1,165	1,080	500	500	1,000

Table 2 illustrates the steady decrease in the number of counties without public health services. When selecting counties to target for development activities, two characteristics are sought: those with large populations which can provide sufficient resources to help support an LHD and those contiguous to a county or counties with an existing LHD. For small rural counties, contracting with an existing health department is frequently the most cost-effective and expedient way to secure basic public health services.

Program Effectiveness

General

Since fiscal year 1989: Bureau, Jefferson, Knox, Sangamon and Washington counties have established new LHDs; Wayne, Hamilton and Stark counties contracted with existing LHDs in neighboring counties to provide public health services in their respective jurisdictions; Woodford, Mercer and Crawford counties contracted with hospitals in the counties to provide public health services. Discussions are underway in Carroll, Edgar, Marion and Warren counties to form LHDs.

Program staff conduct on-site and telephone conferences with personnel at each LHD to review the LHD's progress in implementing the required basic health services and to develop innovative means to achieve the desired quality of services with diminishing resources. Staff conduct at least one annual on-site visit to each LHD.

Once new LHDs establish their basic health programs, they become eligible for the BHSG funding. The Department has diligently worked with the governor's office and the Illinois General Assembly to assure proportional increases in the BHSG appropriation to accommodate the addition of new LHDs. From fiscal year 1987 through fiscal year 1992, the BHSG funding increased from $7.538 million to $8.831 million, an increase of only 5 cents per resident served. The Department continues to seek adjustments to compensate for inflation and increase funding for local health services for all citizens.

Table 3

LOCAL HEALTH SERVICES

Outcome Objectives and Actual Performance

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
Counties without basic public health services						
outcome objective	23	30	18	11	10	0
actual performance	16	16	13	NA	NA	NA
Number of certified local health departments (LHDs)[1]						
outcome objective	74	74	76	80	82	97
actual performance	76	76	78	NA	NA	NA
Number of approved basic health programs						
outcome objective	760	760	760	800	820	970
actual performance	758	756	774	NA	NA	NA
Basic Health Services Grant (BHSG) money spent per capita						
outcome objective	$1.00	$1.00	$1.00	$1.00	$1.00	$1.00
actual performance[2]	.75	.75	.77	NA	NA	NA

1. An LHD is "certified" if it has Departmental approval of all ten basic health programs.
2. 1990 Census used for calculations.

Assurances

Interagency Cooperation

Program staff work with the staff of the Department on Aging and the Department of Public Aid to coordinate LHD services and activities, particularly home health and maternal and child health services. Some LHDs have also established cooperative relationships with the Illinois Environmental Protection Agency in nonhazardous, solid waste programs. Many LHDs have established effective community partnerships with the departments of Transportation, Commerce and Community Affairs and Mental Health and Developmental Disabilities.

Family Impact

LHDs contribute significantly to families through all of their health promotion, education and screening activities, which focus on promoting and protecting the health of residents. The maternal and child health programs promote stability of the family through prenatal and postnatal education, care and follow-up; well-child care and screening and family planning. Other programs promote adult wellness through screening and lifestyle education. Those health departments that provide home health care assist families caring for members who are disabled or ill, thus keeping the family unit intact despite a compromise in health status.

Recommended Changes to Programs

To effectively communicate the importance of funding for LHDs, the Department is identifying methods to demonstrate what services LHDs provide with state general revenue. LHDs provide a number of basic public health services in personal and environmental health. Many personal health services are partially supported by existing categorical grants. Some of the environmental health services have local fees to provide some support. The Department recommends changing the Basic Health Services Grant to the Local Health Protection Grant and to establish a monitoring system to ensure that funds are used to provide four key health protection services—infectious diseases, food sanitation, water safety and private sewage. LHDs would submit data documenting their activities to document services. Performance data would include number of: communicable diseases reported, immunizations administered, environmental health inspections and food inspections.

Legal Citations

Counties Code, 55 ILCS 5/5-25001 *et seq.* (Ill. Rev. Stat. 1991, ch. 34, ¶ 5-25001 *et seq.*)

Public Health District Act, 70 ILCS 905/0.01 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 0.01 *et seq.*)

6F_B_LOC.HSP

Program Title: **Vital Records**

Goal

To process all vital records, statistical data and requests for certified copies accurately and timely.

Needs Assessment

Approximately 500,000 vital records are registered annually with the Illinois Department of Public Health. Staff of the Division of Vital Records must edit each record for consistency and completeness before it is permanently archived. The division also provides certified copies of vital records for proof of age, citizenship, marital status, insurance, estate heirship and pension claims. Additional uses of records include: legal identification for employment changes and applications for driver's license, school enrollment, passports, induction into the armed services, social security benefits and voter registration. The Immigration Reform and Control Act (IRCA) and the Tax Reform Act of 1986 resulted in a significant increase in the number of requests for copies of certified birth records. The IRCA-based requests are for citizenship verification. The Tax Reform Act requires proof of dependents (via presentation of a social security number) 1 year of age and older.

Anyone who has had a vital event (birth, death, fetal death, marriage or dissolution of marriage) recorded in this state is eligible for vital records services. Requests for vital records services come from all over the world. The population served encompasses millions of individuals.

Currently, more than 27,000,000 original birth and death records are stored in the State Archives. Approximately one-fourth of these records are also captured on microfilm. Copies of marriage and divorce records are being retained exclusively on microfilm.

Equally important, the Division of Vital Records collects, edits and retains a multitude of statistical data gleaned from the same documents. Statistical data is essential for medical and social research and public health planning. Birth records are the major source for information on pregnancy outcomes in the United States. Death certificates are the only source of national and state level mortality data. In an average fiscal year, the Division of Vital Records reproduces more than 20,000 research copies and provides hundreds of other reports containing data via its computerized data base.

During fiscal years 1993 and 1994, the division is implementing a two-year, phase-in plan to decentralize the data entry of birth records. Many hospitals now submit data electronically to the state in addition to submitting the hard copy certificate. Birth records prepared in this manner are more accurate due to edits built into the software. (Some hospitals are using the same data submitted to Vital Records to monitor events in their facilities, such as the number of low birthweight babies and Caesarean sections.) Errors made on computer-generated certificates are easily corrected and reprinted, rendering the old method of preparing birth records on a typewriter obsolete.

Program Activities

General Overview

The Division of Vital Records, which administers this program, is advised by the National Center for Health Statistics (NCHS) regarding data sampling, keying and vital records coding accuracy. However, fundamental to the activities of Vital Records is the Quality Control Program (QCP), which ensures accurate, complete and timely posting of information. The major parts of QCP are an educational component, manual checks and an automated editing component.

The educational component consist of periodic outreach training seminars, daily field visits and quarterly publication of the vital records newsletter. Vital records training seminars target coroners, medical examiners, physicians, medical records groups, nurses, local registrars, county clerks, circuit clerks, genealogists and all other interest groups. Active membership on the Advisory Board on Necropsy Service to Coroners provides the division with an excellent opportunity to share information, influence policy and educate coroners on the proper way to report data on the death record.

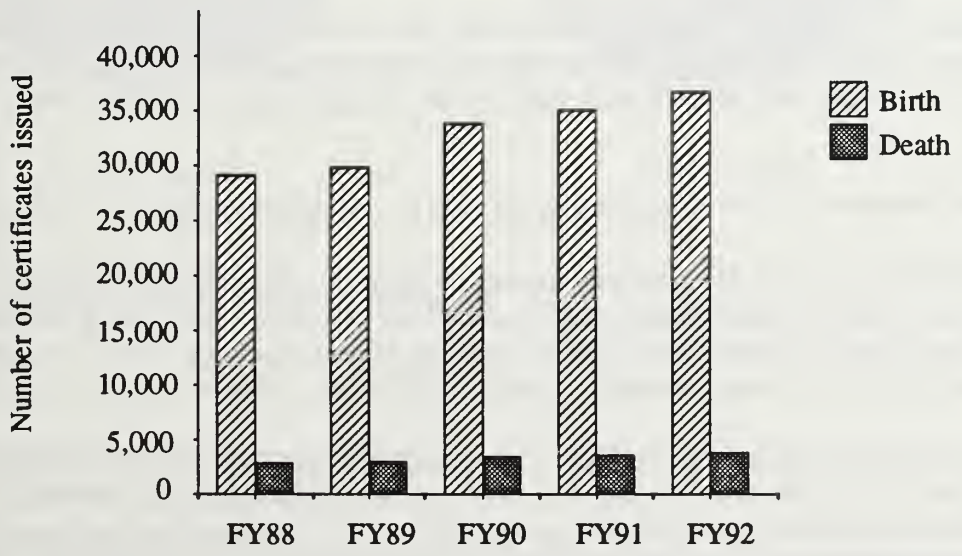
Another element of the educational component is the work of the full-time field representative. This individual returns incomplete and inconsistent documents to the preparer. The field representative reviews with the preparer the rules and procedures governing document submission, to ensure the preparer submits complete and accurate documents in the future.

The third element of the educational component, the newsletter, offers updated information on data preparations, legislative changes and other items of interest to local registrars, county clerks, death investigators, funeral directors and hospitals.

Manual edits are made on all births deaths and fetal deaths registered by the approximately 145 local registrars throughout the state. Vital Records staff inspects every document to verify the completeness and consistency of the information. Final vital records edits are made by computer at the time of data entry. Errors or omissions are queried through the mail for rapid response.

Figure 1

Requests for Birth and Death Certificates
1988 – 1992



Source: Illinois Department of Public Health, Vital Records

Table 1

VITAL RECORDS

Recipients and Activity Measures

	Actual FY90	Actual FY91	Actual FY92	Actual FY93	Estimated FY94	Projected FY2000
RECIPIENTS						
People requesting certified copies of vital records	69,530	68,946	71,409	72,375	72,000	72,500
ACTIVITY MEASURES						
Vital records registered	421,089	436,449	431,850	431,200	435,000	440,000
Vital records amended[2]	20,000	20,000	20,500	21,000	21,500	22,000
Delayed registrations processed	1,427	1,388	1,427	1,276	1,300	1,250
Adoption, legitimation and paternity records processed	9,864	8,702	9,936	10,140	10,250	10,250
Adoption Registry enrollments processed	92	96	116	150	175	200
Records microfilmed[2]	625,000	625,000	625,000	625,000	625,000	625,000
Research copies and verifications provided[2]	20,500	21,000	21,500	21,500	22,000	22,000
Commemorative Certificates of Birth	50	63	95	129	140	150

1. Target population encompasses any individual in the world who has had a vital event recorded in Illinois or is eligible to receive vital records information.
2. Count approximate.

The responsibilities of the Division of Vital Records are organized into several functional units. A description of those responsibilities follow:

The ***Current Registration Unit*** and the ***Coding Unit*** collect, edit, code, query and number approximately 500,000 vital records filed annually. These employees assign geographic and medical codes to documents prior to computer input. Both units participate in the key entry of approximately 195,000 birth certificates annually.

The ***Archives Unit*** permanently stores approximately 500,000 new vital records per year.

The ***Delayed Registration Unit*** annually processes approximately 5,000 applications for delayed records. A delayed registration of birth or death is prepared for those events that were never filed at the time of the occurrence. This legal process allows for the official recording of birth and death events at any time after the occurrence providing proper documentation can substantiate the facts of birth or death.

The ***Adoption and Legitimation Unit*** prepares new birth records for approximately 10,000 adoptions and legitimations per year. The unit also manages the Statewide Adoption Registry which allows for the exchange of adoption information by mutually consenting parties. The Adoption Registry is a confidential cross-reference file of birth parents, siblings and adult adoptees. All persons on file in the Registry have stipulated whether they want their identities to be made known to other parties in the adoption.

The ***Legal Amendment Unit*** processes approximately 20,000 applications for corrections to vital records each year and updates the on-line data base.

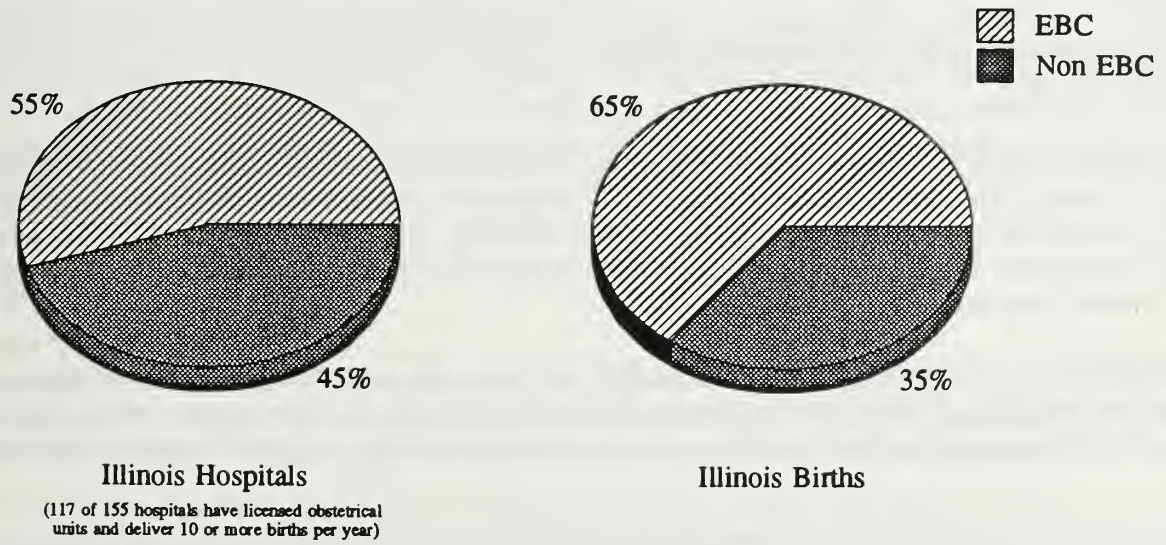
The ***Microfilm Unit*** films approximately 50,000 vital records per month. A copy of this film is sent to the NCHS in compliance with the Vital Statistics Cooperative Program (VSCP). The vital registration and statistics system in the United States is a state-operated and controlled program based on state statutes.

The ***Mail, Search and Fee Receipt Unit*** receives and processes more than 70,000 applications for certified copies each year. Also, each year this unit searches for and makes approximately 30,000 copies of documents used for processing vital records corrections. Due to the legal documentation necessary to amend vital records, approximately 20,000 applications result in actual changes to the records. In addition, this unit provides more than 3,000 research copies and verifications to various organizations throughout the country. Each week more than 100 of these certified records require overnight mailing to locations in the US and abroad for those persons needing expedited service.

The division also coordinates all activities involved in producing the Commemorative Certificates of Birth. This heirloom certificate is prepared on high quality paper with a design that recognizes the heritage of Illinois. The information on each document is entered in calligraphy. The $40 fee collected for each Commemorative Certificate is equally divided between the Illinois Child Abuse Prevention Fund and the Illinois Coalition Against Domestic Violence.

Figure 2

Electronic Birth Certificate (EBC) Utilization
Illinois Hospitals
July 1, 1993



Source: Illinois Department of Public Health, Vital Records

Process Objectives

- Draft and publish a detailed Electronic Birth Certificate (EBC) handbook to help hospital staff operate the EBC software by June 1, 1994.
- Complete decentralization of the automated birth data input system in hospitals throughout Illinois by January 1, 1995.

Program Effectiveness

Table 2 lists four primary measures of performance for the Division of Vital Records. The first objective illustrates the service turnaround time for requests from the general public. The second objective portrays the constant responsibility to register, edit, number, code and data enter the information accurately and in a timely manner. The third objective relates to the accuracy of the cause-of-death coding, essential to producing mortality data. The final objective represents the division's processing speed and participation rate relevant to the Social Security Administration's Enumeration at Birth Program (EAB).

During the last four years the average turnaround time for processing requests was 10 to 12 days, twice the objective of five days. (Staff maintained urgent, next-day service for certified copies, such as proof for passports.) Processing time initially increased due to unfilled vacancies and the inability of the remaining staff to maintain the workload. As vacancies began to be filled, a lag in production continued due to the new employees learning the work and not meeting production speed. The 1992 layoffs and subsequent bumping process again impaired the processing speed of the Search Unit.

Should the number of requests and staffing remain the same, the average turnaround time to the public should continue at 10 days during the 1993 calendar year. The public appreciates and expects expedited service. Also, prompt service promotes excellent public relations for the Department.

Meeting the second outcome objective, related to annual processing time, has been elusive due to increases in work volume, antiquated processing methodologies, the effects of the 1989 birth certificate revision and staffing deficiencies. Processing time for the last two fiscal years has improved primarily due to administrative streamlining and the implementation of EBC. Several of the division's units are co-dependent on output from each other to stay current. Accelerating processing speed at the expense of statistical integrity has not been viewed as a viable option. To achieve the utmost in data accuracy, the present data entry procedures mandate that each birth record entered into the database be entered a second time by a different data entry operator.

The third outcome objective portrays the many years of consistent cause-of-death coding. Maintaining coding error levels under 3 percent has been accomplished. Consistency is fundamental to producing statistical data capable of reflecting accurately the changes and trends in mortality. Researchers depend on this data to make specific observations on the state of health of a given population. Health planners use this information to adjust program emphasis and direction.

During fiscal years 1991 through 1993, data quality has met the standards of acceptability as specified by the National Center for Health Statistics. Manual and automated edits remain in place. Filing timeliness, measured by comparing the date of the event with the filing date, has not degraded during the last several years.

The final objective depicts the division's role in the EAB program of the Social Security Administration (SSA). The purpose of the disclosure of birth information by the state is to allow SSA to enumerate children at their birth and assign a Social Security Number (SSN) to all individuals born in the United States. SSA shall enumerate at birth only in those instances where the parent(s) request the issuance of SSN to their newborn and have given permission to the state to disclose identifying information to SSA.

As required by this program, states enter into a contractual agreement with SSA. Under this arrangement, Illinois sends copies of the magnetic tapes created by the Division of Vital Records based on individual birth registration documents. Since all the information required to issue the SSN is contained on the birth registration document, a number can be assigned and a Social Security card issued to the parents automatically.

Table 2

VITAL RECORDS

Outcome Objectives and Actual Performance

CALENDAR YEAR OCCURENCES

	Actual 1989	Actual 1990	Actual 1991	Actual 1992	Estimated 1993	Projected 2000
Process days for request of certified copies						
outcome objective	5	5	5	5	5	5
actual performance	12	10	11	10	NA	NA
Complete processing cycle						
outcome objective	05/90	05/91	05/92	05/93	05/94	05/2001
actual performance	10/90	11/91	07/92	07/93	NA	NA
Error rate (percent) for cause-of-death coding						
outcome objective	3	3	3	3	3	3
actual performance	3	3	3	3	NA	NA
Submission time (weeks) for birth data tapes						
outcome objective	13	13	13	13	13	13
actual performance	40(80)[1]	35(65)[1]	20(45)[1]	16(50)[1]	NA	NA

1. ( ) = Percent of newborns whose parents request Vital Records submit identifying information to the Social Security Administration for the purpose of obtaining a Social Security Number for the newborns.

Illinois had been providing tapes to SSA within 20 to 40 weeks after the birth. This unacceptable turnaround time resulted from staffing shortages, turnover of experienced staff, changes in forms, increases in data entry workload and the need to redesign the data entry processing system. (This delay contributed to the decline in parental participation.) During the past three years the division made significant progress, reducing the turnaround time by 60 percent.

Assurances

Interagency Cooperation

Various agencies use the statistical data abstracted from all vital records. Much of this information is essential to identifying serious public health problems or threats and direct medical research efforts. Death records provide a uniform method to determine the leading cause of death at national and state levels.

The Illinois Department of Public Aid (IDPA) routinely uses indexes of death and marriage records to detect fraudulent claims for public assistance entitlement. IDPA's Child Support Enforcement Unit also locates fathers and, less frequently, mothers refusing to support their children and pursues legal avenues necessary to obtain support. SSA, State Employees' Retirement and Teachers Retirement Systems use the death indexes to discover fraudulent cashing of beneficiaries' checks. The Secretary of State's office uses death record information to prevent mailing of driver's license renewal notices to avoid distressing survivors.

Family Impact

The Division of Vital Records plays a key role in the operation of the I-SEARCH (Illinois State Enforcement Agencies to Recover Children) identification program administered by the Illinois State Police. The I-SEARCH Program reunites children with their families. Birth records of missing children are marked or "flagged" at the state and local levels. Requests of flagged records are immediately reported to local law enforcement authorities in the event the requestor has some information on the child's whereabouts.

SSA uses state computer tapes to automatically issue an SSN to newborns. The new SSN is mailed directly to the parents and the entire process is cost free to the public.

Effective September 1, 1989, Chapter 111½, paragraph 73 of the Illinois Vital Records Act, requires the Division of Vital Records to match all death records with the appropriate birth record. This antifraud measure is designed to help protect the public from unscrupulous individuals assuming good identities to elude capture, participate in baby selling, enter this country illegally, defraud business and the public and avoid criminal prosecution.

Recommended Changes to Program

The division recommends that occupation and industry codes be included in the birth and death records posted to the Vital Records database. The division believes that such information would aid studies that try to ascertain a cause and effect relationship between certain occupations and specific causes of death. Valuable data essential to linking certain occupations and industries to specific causes of death would be available for future computer retrieval and study.

Other long term solutions are needed for efficient, accurate and timely collection, data entry, retrieval and storage of vital records data. Various technologies in addition to microfilm need to be explored, including optical scanning and imaging. The division intends to develop a short term (one to two years) and a long term (three to five years) technological improvement plans to automate the processing of incoming registrations.

The division is pursuing cost-effective means of automating the marriage, divorce and death registration processing systems. The division intends to have the automated death record information coincide with the revised *International Classification of Diseases, 10th Revision* (ICD 10).

In addition, if the division is to prevent the loss of 60 percent of vital records information on file, funds must be appropriated for microfilming 6.5 million deteriorating paper records of events that occurred prior to calendar year 1950.

Legal Citations

Adoption Act, 750 ILCS 50/0.01 *et seq.* (Ill. Rev. Stat. 1991, ch. 40, ¶ 1500 *et seq.*)

Counties Code, 55 ILCS 5/3-3017 (Ill. Rev. Stat. 1991, ch. 34, ¶ 3-3017)

Immigration Reform Control Act of 1986, 42 USC 303 (100 stat. 3359)

Marriage, Dissolution and Invalidity Record Act, 410 ILCS 530/0.01 *et seq.* (Ill. Rev. Stat. 1991, ch. 40, ¶ 900 *et seq.*)

Tax Reform Act of 1986, 42 USC 1395u (100 Stat. 1951)

Vital Records Act, 410 ILCS 535/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 111½, ¶ 73-1 *et seq.*)

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CHAPTER VII

OFFICE OF THE DIRECTOR

Introduction

Mission

To formulate policy and procedures for the general operations and management of the Department.

Summary of Responsibilities

Program Overview
To accomplish its mission, the Office of the Director performs the following functions: manages the day-to-day operations of the Department; mobilizes staff to carry out the director's priorities and interprets established directives. These activities, coordinated by the Assistant Director and the Deputy Directors, promote effective management within the Department and cooperation with other agencies.

Divisions

The office carries out its mission through the following divisions:

The ***Affirmative Action/Equal Employment Opportunity Office*** supports, coordinates and monitors Department policy of nondiscrimination consistent with state and federal mandates for equal opportunity in employment and services.

The ***Center for Minority Health*** assists in assessment of the health needs of ethnic and racial populations, promotes awareness of minority health concerns, provides opportunities for minority populations to express views to the Department, promotes services that are sensitive and relevant to the unique linguistic, cultural and ethnic characteristics of minority populations and provides consultation, training and technical assistance to Department staff and service providers.

The ***Center for Rural Health*** identifies community health needs in rural areas, provides direct services and technical assistance to community organizations in underserved areas and administers educational scholarship and loan programs. Since this division's programs supports direct services to Illinois residents, more detailed information is in the next section of this chapter.

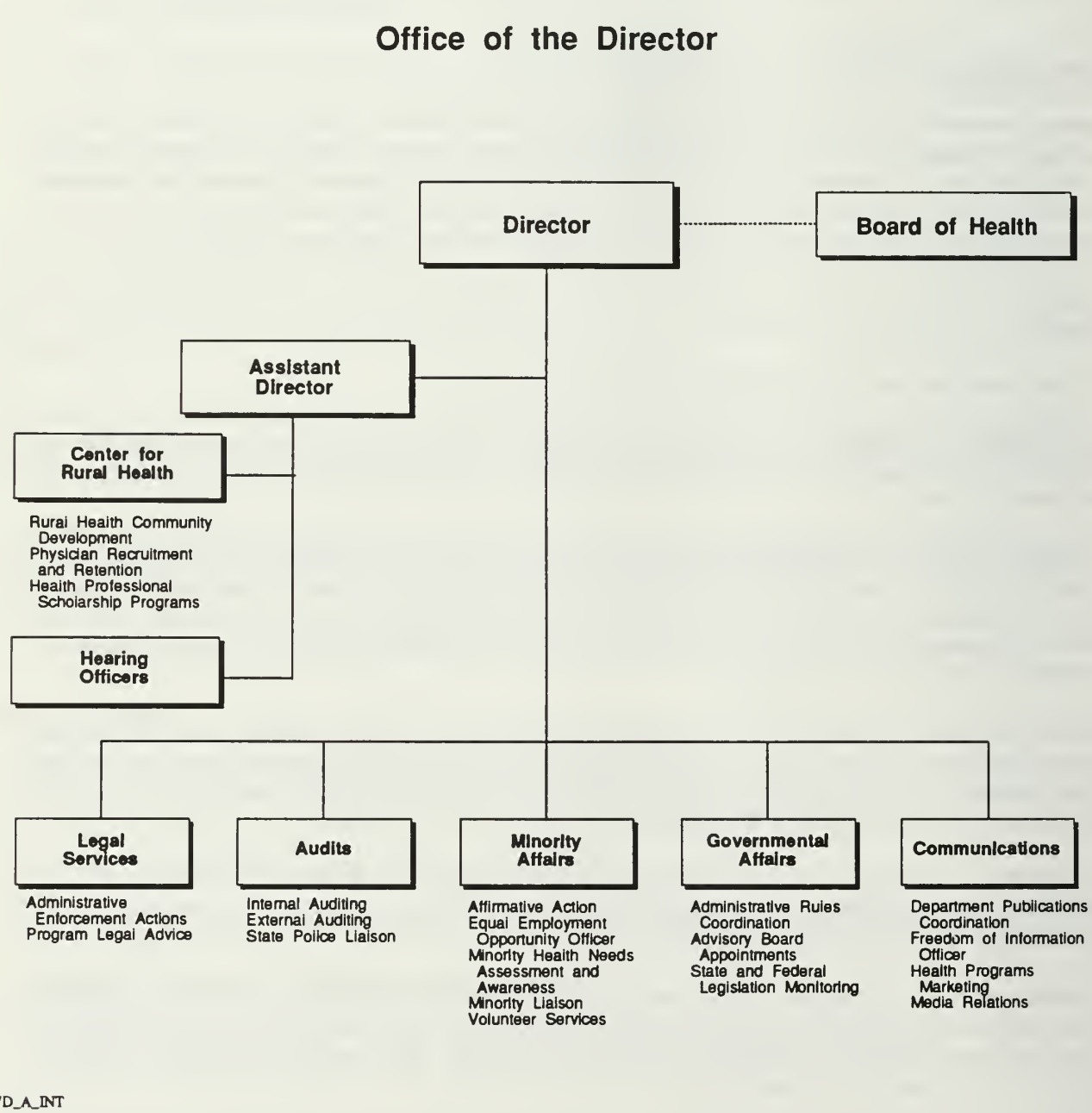
The ***Division of Audits*** performs independent reviews of Department's internal accounting procedures, administrative control systems, electronic data processing systems and other reviews necessary to ensure compliance with professional ethics and standards.

The ***Division of Communications*** issues advisories regarding public health threats and risk, provides the public and media with information on health-related topics and on the Department's programs and activities, develops marketing strategies for priority programs and coordinates the Department's handling of requests pursuant to the Freedom of Information Act.

The ***Division of Governmental Affairs*** serves as the Department's liaison with the Illinois General Assembly and U.S. Congress, and coordinates the preparation of new legislation, amendments to existing legislation and promulgation of rules and regulations required to administer mandated programs.

The ***Division of Legal Services*** advises and assist staff on legal issues related to Department programs, such as interpretation and application of statutes and rules, rule development, contract development and review, investigation and enforcement activities; represents the Department in administrative hearings; coordinates referrals to the Illinois Attorney General or state's attorneys; participates in interagency and health care industry programs related to Department functions and responds to outside legal inquiries related to Department activities.

Figure 1



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Program Title: **Center for Rural Health**

Goal

To improve access and availability to primary care in underserved areas.

Needs Assessment

In rural Illinois adequate health care services are a major concern. The primary reasons are reduced access and availability. Several factors contribute to this situation. The demographics show that this population continues to decrease. Generally, it is older and poorer than the nonrural population and cannot pay for the costs of new technology as easily as the state's nonrural population. Young physicians, accustomed to the training resources available at large urban hospitals, are less likely to serve in rural areas due to the lack of modern technology. The variance between the cost of providing care and reimbursement offered by the largest payer for many rural hospitals—Medicare—continues to increase, further discouraging healthcare professionals from locating in rural areas. The combination of reduced reimbursement and decreasing number of physicians forces rural hospital closures.

The Department collects information on the number of healthcare providers in Illinois. It uses this information to classify areas that have an insufficient number of primary care physicians (i.e., family physicians, internists, pediatricians, obstetricians and gynecologists) as Designated Shortage Areas (DSAs). The Department also uses this information to document its requests to the U.S. Department of Health and Human Services (DHHS) to designate specific population groups and service areas as Health Professional Shortage Areas (HPSAs), i.e., areas with insufficient numbers of primary care physicians. As of July 1, 1992, Illinois had 26 counties, 31 service areas and 2 population groups designated as HPSAs. In addition, 39 other counties or service areas are designated as underserved for purposes of rural health clinic certification only. Illinois ranks fourth highest among states with persons living in HPSAs.

The purpose of designating DSAs and HPSAs is to make these areas eligible for state and federal money targeted for medically underserved areas. Health care providers request federal Rural Health Clinic certification for the same reason. Medicare and Medicaid increase reimbursements to certain providers in these areas. The Department provides scholarships and loans to medical education students in exchange for their contractual commitment to practice in these areas upon completion of their training. The Department also awards funds to family practice residency programs that give family practice residents real-life educational experiences in inner-city neighborhoods and rural areas where few resources are available. The short-term goal is to increase the accessibility and availability of health care services in underserved areas. The long-term goal is to eliminate the need for DSA and HPSA classifications.

Resources exist in many areas to significantly improve availability and access to health care in rural areas. The challenge is to develop innovative health care delivery systems that maximize available local, state and federal resources and improve the coordination of economic and social services. The target population is the just more than 2.0 million persons (18.1 percent of the state's population) who live in urban and rural communities that have an insufficient number of primary care physicians.

Program Activities

General Overview

The Center for Rural Health is a division within the Office of the Director. The Department established the division in April 1989 in response to the needs of rural Illinois. Staff work with local community leaders who significantly influence local healthcare decision making. The purpose is to help rural community leadership define specific healthcare needs of residents and identify strategies that fulfill those needs. Once these needs and strategies are defined, division staff marshal the required resources.

Another way the center helps underserved areas is through scholarship and loan programs. Recipients sign a commitment to serve in DSA and HPSA areas. To further help with primary care physician recruitment, the center will publish "Physician Recruitment in Illinois" during fiscal year 1994. It will distribute this handbook to underserved communities and will also send the handbook with the Preferred Practice Questionnaire to Medical Student Scholarship recipients in their second or third years in residency.

The funding for the Illinois Medical Student Scholarship program has remained at the same level in recent years. But medical school tuition has increased. The result is a decreasing number of scholarships awarded each year to medical students.

In an effort to address the nursing shortage in Illinois, the Department provides educational funds to nurses, allowing qualified individuals the opportunity to enter or further their education in the nursing profession. The funding of nursing education is in transition between the discontinued Baccalaureate Nursing Assistance Program and the recently created Nursing Education Scholarship Program.

Program Data

Table 1

CENTER FOR RURAL HEALTH

Recipients and Activity Measures

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
RECIPIENTS OF:						
medical scholarships	141	128	124	117	109	60
physician education repayment loan	1	12	12	0[1]	0[1]	0[1]
family practice resident special project grants	11	12	12	12	12	15
nursing education scholarships	0[2]	0[2]	0[2]	75	75	0
baccalaureate nursing student loan	298	306	284	0[1]	0[1]	0[1]
ACTIVITY MEASURES						
Number of new applications processed for:						
medical scholarships	83	106	88	117	125	135
physician education repayment loan	2	18	30	0[1]	0[1]	0[1]
family practice resident special project grants	11	12	12	12	12	15
nursing education scholarships	0[2]	0[2]	0[2]	300	100	0
baccalaureate nursing student loan	273	341	376	0[1]	0[1]	0[1]

1. Funding was eliminated in fiscal year 1993.
2. The Nursing Education Scholarship Program began providing assistance in fiscal year 1993.

Loans—The 86th Illinois General Assembly amended (effective September 17, 1989) the Family Practice Residency Act, establishing a tax exempt medical education loan repayment program. The program repays physicians with the lesser of 25 percent or $20,000 of their education-related expenses. The Department received few applications during fiscal year 1990. However, as physicians became aware of the program, the number of applications significantly increased in fiscal years 1991 and 1992. Due to budgetary constraints, funding was reduced in fiscal year 1992 and eliminated in fiscal year 1993.

During fiscal years 1985 through 1992, the Department's Baccalaureate Nursing Assistance Program provided loans to 1,971 Illinois registered nurses pursuing their baccalaureate degree in nursing. The recipients satisfied these loans through their subsequent employment in Illinois or pursuit of an advanced degree in nursing. The program, however, lost its funding in fiscal year 1993.

Scholarships—The Department awarded 42 medical education scholarships in fiscal years 1979 through 1981. The Department did not award any scholarships in fiscal years 1982 through 1984 due to budget restrictions. Since the reinstatement of funding in fiscal year 1985, 338 students have received medical education scholarships.

In fiscal year 1993, the Nursing Education Scholarship Program became operational. Educational funds were expanded to include all students who pursue training in nursing. The scholarship requires the recipient to practice nursing in Illinois upon completion of the certificate or degree. The Department expects to award 75 scholarships in fiscal year 1993.

Residency Programs—The number of special projects funded through the Family Practice Residency Program remained relatively stable as the funding level continued unchanged through fiscal year 1991. Reductions in funding for fiscal years 1992 and 1993 resulted in smaller awards to existing projects. Currently, 13 of 24 Family Practice Residencies in Illinois receive grants from the Department.

Program Effectiveness

Table 2

CENTER FOR RURAL HEALTH

Outcome Objectives and Actual Performance

	Actual FY90	Actual FY91	Actual FY92	Estimated FY93	Projected FY94	Projected FY2000
Number of medical scholarship or loan recipients who honor their commitment to practice in medically underserved areas of Illinois						
process objective[1]	31	27	44	34	53	50
actual performance	31	27	44	NA	NA	NA
Number of rural communities, providers and health services facilities receiving technical assistance						
process objective	0	20	20	30	32	40
actual performance	18	29	23	NA	NA	NA
Number of rural local health departments and other social service providers receiving technical assistance to develop primary care service system						
process objective	0	0	1	10	15	12
actual performance	1	1	2	NA	NA	NA

1. The number of recipients completing their education.

The program has helped representatives from 53 communities develop their health care services. It assisted with 22 local surveys to determine the perceived needs of the local communities.

Since fiscal year 1985, the Baccalaureate Nursing Assistance Program awarded loans to 1,143 Illinois registered nurses. Of those loan recipients, 825 received their baccalaureate degree and have helped meet the specialized needs of the healthcare systems throughout Illinois.

Assurances

Interagency Cooperation

The Board of Higher Education is closely involved and very supportive of the Medical Student Scholarship and Baccalaureate Nursing Assistance Programs. The center works closely with the Department of Public Aid and the Lt. Governor's Rural Affairs Council in responding to communities' requests for assistance. Staff from those agencies and Southern Illinois University, Sangamon State University and Western Illinois University assist with community surveys.

Family Impact

This program promotes the health and well-being of Illinois families who live in underserved areas by helping community leaders increase the availability of and accessibility to services provided by health care professionals.

Recommended Changes to Program

The center recommends the following: increase the funding for the Family Practice Residency Program that increase the number of programs providing health care services to underserved areas; reinstate funding for the Illinois Physicians Educational Loan Repayment Program and modify the appropriation mechanism to make the program an effective physician recruitment tool. Increased funding would allow the Department to expand the Family Practice Residency Program to include additional residency training experiences.

Legal Citations

Baccalaureate Assistance Law for Registered Nurses, 110 ILCS 915/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 144, ¶ 1401 *et seq.*)

Family Practice Residency Act, 110 ILCS 935/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 144, ¶ 1451 *et seq.*)

Nursing Education Scholarship Act, 110 ILCS 975/1 *et seq.* (Ill. Rev. Stat. 1991, ch. 144, ¶ 2751 *et seq.*)

Rural Health Act, 410 ILCS 65/1 (Ill. Rev. Stat. 1991, ch. 111½, ¶ 8051)

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APPENDIX I

Office of Community Health
Table A-1 FY95 Budget Summary
($ thousands)

Appropriation Request

	GRF	State Project	Hearing Aid	Metab Scrng	Alzhmr Disease	Immig	Sex Assault	Brst/Cvcl Cancer	Lead Poison	MCH	PHS	WIC	Fed Proj	MCH Block	PHHS Block	TOTAL
Office of the Deputy Director	1,826.7									568.4	317.4	1,148.5		996.4	76.2	4,933.6
Fiscal Operations	360.9										70.4	168.2		123.8	44.4	767.7
Family Health	21,758.1	233.0		2,031.9					1,937.9		19,939.4	75.3	55.0	51,315.2		97,345.8
Dental Health	383.5													974.4	45.0	1,402.9
Health Assessment and Screening	1,686.2		110.0							60.0		196,681.9		50.0	·	198,588.1
Health Promotion	7,996.1				200.0	1,000.0	75.0	350.0			4,124.8	83.2	152.0	112.0	8, 037.9	22,131.0
TOTAL	34,011.5	233.0	110.0	2,031.9	200.0	1,000.0	75.0	350.0	1,937.9	628.4	24,452.0	198,157.1	207.0	53,571.8	8,203.5	325,169.1

Projected Expenditures

	GRF	State Project	Hearing Aid	Metab Scrng	Alzhmr Disease	Immig	Sex Assault	Brst/Cvcl Cancer	Lead Poison	MCH	PHS	WIC	Fed Proj	MCH Block	PHHS Block	TOTAL
Office of the Deputy Director	1,826.7									568.4	317.4	1,148.5		996.4	76.2	4,933.6
Fiscal Operations	360.9										70.4	168.2		123.8	44.4	767.7
Family Health	21,247.9	233.0		2,031.9					1,937.9		19,939.4	75.3	55.0	50,779.5		96,299.9
Dental Health	383.5													974.4	45.0	1,402.9
Health Assessment and Screening	1,686.2		110.0							60.0		195,691.1		50.0		197,597.3
Health Promotion	7,996.1				200.0	1,000.0	75.0	350.0			3,880.3	83.2	152.0	112.0	7,955.9	21,804.5
TOTAL	33,501.3	233.0	110.0	2,031.9	200.0	1,000.0	75.0	350.0	1,937.9	628.4	24,207.5	197,166.3	207.0	53,036.1	8,121.5	322,805.9

Office of Community Health
Table A-2 FY94 Budget Summary
($ thousands)

Appropriation

	GRF	State Project	Hearing Aid	Metab Scrng	Alzhmr Disease	Immig	Brst/Cvcl Cancer	Lead Poisoning	MCH	PHS	WIC	Fed Proj	MCH Block	PHHS Block	TOTAL
Office of the Deputy Director	1,305.6									187.5	1,004.2		648.4	126.9	3,272.6
Family Health	21,817.9	233.0		2,400.0				1,745.7	691.6	18,643.2	86.6	50.3	42,853.4		88,521.7
Dental Health	382.1											5.0	715.2		1,102.3
Health Assessment and Screening	1,435.2		105.0						60.0	10.7	178,955.4		50.0		180,616.3
Health Promotion[1]	7,025.7				200.0	3,250.0	250.0			4,849.2	123.1	55.0	120.0	7,627.2	23,500.2
TOTAL	31,966.5	233.0	105.0	2,400.0	200.0	3,250.0	250.0	1,745.7	751.6	23,690.6	180,169.3	110.3	44,387.0	7,754.1	297,013.1

Estimated Expenditures

	GRF	State Project	Hearing Aid	Metab Scrng	Alzhmr Disease	Immig	Brst/Cvcl Cancer	Lead Poisoning	MCH	PHS	WIC	Fed Proj	MCH Block	PHHS Block	TOTAL
Office of the Deputy Director	1,305.6									187.5	1,004.2		648.4	126.9	3,272.6
Family Health	21,810.9	233.0		2,400.0				1,745.7	691.6	18,643.2	86.6	50.3	14,865.0		60,526.3
Dental Health	382.1											5.0	715.2		1,102.3
Health Assessment and Screening	1,435.2		105.0						60.0	10.7	178,079.1		50.0		179,740.0
Health Promotion[1]	7,025.7				200.0	3,250.0	250.0			3,990.3	123.1	55.0	120.0	3,523.7	18,537.8
TOTAL	31,959.5	233.0	105.0	2,400.0	200.0	3,250.0	250.0	1,745.7	751.6	22,831.7	179,293.0	110.3	16,398.6	3,650.6	263,179.0

[1]Effective July 1, 1993 the Divisions of Adult and Senior Health and Health Promotion were combined into a single unit.

Office of Community Health
Table A-3 FY93 Budget Summary
($ thousands)

Appropriation

	GRF	State Project	Hearing Aid	Metab Scrng	Alzhmr Disease	Immig	Lead Poisoning	MCH	PHS	WIC	Fed Proj	MCH Block	PHHS Block	TOTAL
Office of the Deputy Director	1,305.6								80.8	287.9		632.7	1,431.5	3,738.5
Family Health	21,390.1	33.0		1,585.0			2,575.2	477.4	17,508.9		50.3	43,215.7		86,835.9
Adult and Senior Health	6,808.2				250.0	2,250.0			3,242.9				1,932.4	14,483.5
Dental Health	382.1											503.4		885.5
Health Assessment and Screening	1,435.2		101.5					69.5	9.7	172,301.0		50.0		173,966.9
Health Promotion	217.5								145.3	45.4	99.0	116.2	3,039.8	3,663.2
TOTAL	31,538.7	33.0	101.5	1,585.0	250.0	2,250.0	2,575.2	546.9	20,987.6	172,634.3	149.3	44,518.0	6,403.7	283,573.2

Actual Expenditures

	GRF	State Project	Hearing Aid	Metab Scrng	Alzhmr Disease	Immig	Lead Poisoning	MCH	PHS	WIC	Fed Proj	MCH Block	PHHS Block	TOTAL
Office of the Deputy Director	1,305.6								93.0	235.3		186.2		1,820.1
Family Health	21,346.2			1,228.2			48.1	342.2	11,230.0			20,205.4		54,400.1
Adult and Senior Health	6,410.0				139.8	1,298.4			640.3				1,970.3	10,458.8
Dental Health	382.1											487.4		869.5
Health Assessment and Screening	1,435.2		84.7					10.0		142,751.7		50.0		144,331.6
Health Promotion	217.5								12.7	30.0		100.3	1,042.0	1,402.5
TOTAL	31,096.6	0	84.7	1,228.2	139.8	1,298.4	48.1	352.2	11,976.0	143,017.0	0	21,029.3	3,012.3	213,282.6

Office of Community Health
Table A-4 FY92 Budget Summary
($ thousands)

Appropriation

	GRF	State Project	Hearing Aid	Metab Scrng	Alzhmr Disease	MCH	PHS	WIC	Fed Proj	MCH Block	PHHS Block	TOTAL
Office of the Associate Director	3,079.2						31.7	131.2		67.0	3,846.7	7,155.8
Family Health	22,443.2	31.4		1,505.6		324.3	13,144.2	500.0	47.9	46,193.4		84,190.0
Adult and Senior Health	7,384.1				261.3		2,760.4				813.0	11,218.8
Dental Health	559.7									60.0		619.7
Alcohol and Substance Testing	690.7											690.7
Health Assessment and Screening[1]	8,352.0		95.9			44.9	38.6	155,746.2				164,277.6
Health Promotion	308.6						208.1	14.5		83.4		614.6
TOTAL	42,817.5	31.4	95.9	1,505.6	261.3	369.2	16,183.0	156,391.9	47.9	46,403.8	4,659.7	268,767.2

Actual Expenditures

	GRF	State Project	Hearing Aid	Metab Scrng	Alzhmr Disease	MCH	PHS	WIC	Fed Proj	MCH Block	PHHS Block	TOTAL
Office of the Associate Director	2,110.3						30.1	118.2		62.9	1,248.8	
Family Health	21,830.6	3.8		776.8		243.6	10,201.4	469.8		20,458.1		53,984.1
Adult and Senior Health	7,030.2				154.5		322.0				555.9	8,062.6
Dental Health	551.5										27.8	579.3
Alcohol and Substance Testing[1]	683.4											683.4
Health Assessment and Screening	7,853.8		67.3			25.0	16.3	132,334.4				140,296.8
Health Promotion	284.8						40.6	8.0		80.1		413.5
TOTAL	40,344.6	3.8	67.3	776.8	154.5	268.6	10,610.4	132,930.4	0	20,628.9	1,804.7	207,590.0

[1] Organizationally transferred to Office of Health Care Regulation on July 1, 1991, but appropriation remained in Office of Community Health for FY92.

Office of Community Health
Table A-5 FY91 Budget Summary
($ thousands)

Appropriation

	GRF	State Project	Hearing Aid	Metab Scrng	Alzhmr Disease	MCH	PHS	WIC	Fed Proj	MCH Block	PHHS Block	TOTAL
Office of the Associate Director	2,178.0						26.8	60.9		50.0	2,741.6	5,057.3
Family Health	19,249.8	55.0		1,366.6		681.9	9,989.1		45.8	43,744.9		75,133.1
Chronic Diseases	8,477.2				250.0		1,318.9				864.6	10,910.7
Dental Health	530.1									20.7		550.8
Alcohol and Substance Testing	755.8											755.8
Health Assessment and Screening	8,676.5		91.8				29.4	133,990.8				142,788.5
Health Promotion	300.2						344.5			60.0		719.3
TOTAL	40,182.2	55.0	91.8	1,366.6	250.0	681.9	11,708.7	134,051.7	45.8	43,875.6	3,606.2	235,915.5

Actual Expenditures

	GRF	State Project	Hearing Aid	Metab Scrng	Alzhmr Disease	MCH	PHS	WIC	Fed Proj	MCH Block	PHHS Block	TOTAL
Office of the Associate Director	2,184.5						28.9	60.5		56.7	1,153.6	3,484.2
Family Health	18,793.4	47.2		543.4		246.2	9,263.9		34.1	18,875.8		47,804.0
Chronic Diseases	8,422.0				141.4		344.9				581.5	9,489.8
Dental Health	530.3											530.3
Alcohol and Substance Testing	714.0											714.0
Health Assessment and Screening	8,460.9		68.7				17.0	122,572.0				131,118.6
Health Promotion	300.2						181.6			56.1		537.9
TOTAL	39,405.3	47.2	68.7	543.4	141.4	246.2	9,836.3	122,632.5	34.1	18,988.6	1,735.1	193,678.8

Office of Community Health
Table A-6 FY90 Budget Summary
($ thousands)

Appropriation

	GRF	State Project	Hearing Aid	Alzhmr Disease	MCH	PHS	WIC	Fed Proj	MCH Block	PHHS Block	TOTAL
Office of the Associate Director	492.6					25.5	87.3		42.7	2,375.3	3,023.4
Family Health	19,240.0	65.0			655.7	9,960.3		44.0	40,317.1		70,282.1
Chronic Diseases	8,088.4			219.5		757.0				1,097.2	10,162.1
Emergency Medical Services	3,196.3	12.5								190.5	3,399.3
Dental Health	499.2										488.2
Alcohol and Substance Testing	696.6										696.6
Health Assessment and Screening	9,942.5		131.3			28.3	108,756.1				118,858.2
Health Promotion	300.8					331.3			55.6		687.7
TOTAL	42,445.4	77.5	131.3	219.5	655.7	11,102.4	108,843.4	44.0	40,415.4	3,663.0	207,597.6

Actual Expenditures

	GRF	State Project	Hearing Aid	Alzhmr Disease	MCH	PHS	WIC	Fed Proj	MCH Block	PHHS Block	TOTAL
Office of the Associate Director	492.6					25.1	54.0		39.4	1,120.7	1,732.1
Family Health	19,516.8	35.7			197.2	8,715.4		43.6	21,769.4		50,278.1
Chronic Diseases	6,370.5			196.2		367.8				695.1	7,629.6
Emergency Medical Services	3,185.8	12.2								162.9	3,360.9
Dental Health	474.3										474.3
Alcohol and Substance Testing	690.5										690.5
Health Assessment and Screening	9,674.3		59.6			1.2	103,583.0				113,318.1
Health Promotion	295.7					199.4			55.0		550.1
TOTAL	40,700.8	47.9	59.6	196.2	197.2	9,308.9	103,637.0	43.6	21,863.8	1,978.7	178,033.7

Office of Health Protection
Table A-7 FY95 Budget Summary
($ thousands)

Appropriation Request

	GRF	Pest Cont	Metabolic Scrning	Water Permit	School Asbestos	Used Tire Mgnt	Tanning Facility	Plmbng Lic	Lab Revlvng	Food/Drug Safety	Ped/Adult Aids	Lead Posnig	PHS	MCH Block	TOTAL
Office of the Deputy Director	10,202.7							800.0					75.0		11,077.7
Infectious Diseases	12,508.8										150.0		26,911.4	500.0	40,070.2
Food, Drugs and Dairies	2,027.5						500.0			150.0			25.0		2,702.5
Environmental Health	2,330.6	230.0		300.0	550.0	450.0						450.0	2,813.3		7,124.4
Laboratories	8,623.6		2,100.0						900.0			830.0	760.3		13,213.9
TOTAL	35,693.2	230.0	2,100.0	300.0	550.0	450.0	500.0	800.0	900.0	150.0	150.0	1,280.0	30,585.5	500.0	74,188.7

Projected Expenditures

	GRF	Pest Cont	Metabolic Scrning	Water Permit	School Asbestos	Used Tire Mgnt	Tanning Facility	Plmbng Lic	Lab Revlvng	Food/Drug Safety	Ped/Adult Aids	Lead Posnig	PHS	MCH Block	TOTAL
Office of the Deputy Director	10,057.8							800.0					74.2		10,932.0
Infectious Diseases	12,319.2										150.0		26,642.3	500.0	39,611.5
Food, Drugs and Dairies	1,995.1						500.0			150.0			24.7		2,669.8
Environmental Health	2,293.5	230.0		300.0	550.0	450.0						450.0	2,785.7		7,059.2
Laboratories	8,492.2		2,100.0						900.0			830.0	752.7		13,074.9
TOTAL	35,157.8	230.0	2,100.0	300.0	550.0	450.0	500.0	800.0	900.0	150.0	150.0	1,280.0	30,279.6	500.0	73,347.4

Office of Health Protection
Table A-8 FY94 Budget Summary
($ thousands)

Appropriation

	GRF	Pest Cont	Metabolic Scrning	Water Permit	School Asbestos	Used Tire Mgnt	Tanning Facility	Plmbng Lic	Lab Revlvng	Food/Drug Safety	Ryan White	Lead Posnig	PHS	MCH Block	TOTAL
Office of the Deputy Director	9,523.5							800.0					4.2		10,327.7
Infectious Diseases	11,159.1										100.0		19,697.3	1,026.4	31,982.8
Food, Drugs and Dairies	2,008.9						500.0			150.0					2,658.9
Environmental Health	3,476.8	200.0		400.0	480.0	450.0						450.0	5,334.3		10,791.1
Laboratories	9,153.2		2,500.0						1,250.0			728.0	500.5		14,131.7
TOTAL	35,321.5	200.0	2,500.0	400.0	480.0	450.0	500.0	800.0	1,250.0	150.0	100.0	1,178.0	25,536.3	1,026.4	69,892.2

Estimated Expenditures

	GRF	Pest Cont	Metabolic Scrning	Water Permit	School Asbestos	Used Tire Mgnt	Tanning Facility	Plmbng Lic	Lab Revlvng	Food/Drug Safety	Ryan White	Lead Posnig	PHS	MCH Block	TOTAL
Office of the Deputy Director	9,523.5							600.0							10,123.5
Infectious Diseases	10,952.3										100.0		19,693.4	626.4	31,372.1
Food, Drugs and Dairies	2,008.9						500.0			150.0					2,658.9
Environmental Health	3,476.8	200.0		400.0	480.0	260.0						450.0	1,851.6		7,118.4
Laboratories	8,992.3		2,500.0						500.0			728.0	452.8		13,173.1
TOTAL	34,953.8	200.0	2,500.0	400.0	480.0	260.0	500.0	600.0	500.0	150.0	100.0	1,178.0	21,997.8	626.4	64,446.0

Office of Health Protection
Table A-9 FY93 Budget Summary
($ thousands)

Appropriation

	GRF	Pest Control	Metabolic Screening	Water Permit	School Asbestos	Used Tire Mgnt	Tanning Facility	Plumbing Licensure	Ryan White	Lead Poison	PHS	MCH Block	PHHS Block	TOTAL
Office of the Deputy Director	9,315.9							150.0						9,465.9
Infectious Diseases	8,082.3								150.0		15,584.1	947.9		24,764.3
Food, Drugs and Dairies	1,792.4						500.0						229.1	2,521.5
Environmental Health	2,829.4	261.0		434.0	480.0	300.0				276.4	936.1			5,516.9
Laboratories	3,765.7		1,520.0							500.0	563.1			6,348.8
TOTAL	25,785.7	261.0	1,520.0	434.0	480.0	300.0	500.0	150.0	150.0	776.4	17,083.3	947.9	229.1	48,617.4

Actual Expenditures

	GRF	Pest Control	Metabolic Screening	Water Permit	School Asbestos	Used Tire Mgnt	Tanning Facility	Plumbing Licensure	Ryan White	Lead Poison	PHS	MCH Block	PHHS Block	TOTAL
Office of the Deputy Director	9,315.9							80.1			10,831.0			20,227.0
Infectious Diseases	7,809.0								0			173.6		7,982.6
Food, Drugs and Dairies	1,764.8						91.6				671.4		225.9	2,753.7
Environmental Health	2,807.3	195.9		196.0	380.1	257.6				40.3				3,877.2
Laboratories	3,641.3		1,502.8							152.5	154.6			5,451.2
TOTAL	25,338.3	195.9	1,502.8	196.0	380.1	257.6	91.6	80.1	0	192.8	11,657.0	173.6	225.9	40,291.7

Office of Health Protection
Table A-10 FY92 Budget Summary
($ Thousands)

Appropriation

	GRF	Pesticide Control	Metabolic Screening	Water Permit	School Asbestos	Used Tire Mgnt	MCH	PHS	MCH Block	PHHS Block	TOTAL
Office of the Associate Director	801.5										801.5
Infectious Diseases	8,550.1							15,044.0	894.4		24,488.5
Food, Drugs and Dairies	2,002.3									218.2	2,220.5
Environmental Health	3,536.8	151.3		405.0	418.0	282.6		902.8			5,696.5
Epidemiologic Studies[1]	769.1										769.1
Laboratories	4,276.0		1,446.6				115.0	507.2			6,344.8
TOTAL	19,935.8	151.3	1,446.6	405.0	418.0	282.6	115.0	16,454.0	894.4	218.2	40,320.9

Actual Expenditures

	GRF	Pesticide Control	Metabolic Screening	Water Permit	School Asbestos	Used Tire Mgnt	MCH	PHS	MCH Block	PHHS Block	TOTAL
Office of the Associate Director	557.0										557.0
Infectious Diseases	8,259.3							7,768.9	346.4		16,374.6
Food, Drugs and Dairies	1,993.9									108.6	2,102.5
Environmental Health	3,504.0	151.3		275.4	350.1	231.4		859.5			5,371.7
Epidemiologic Studies[1]	758.9										758.9
Laboratories	3,983.3		1,391.4					129.1			5,503.8
TOTAL	19,056.4	151.3	1,391.4	275.4	350.1	231.4	0	8,757.5	346.4	108.6	30,668.5

[1]Organizationally moved to Office of Health Policy and Planning in May, 1991. The funds, however, remained in the Office of Health Protection.

Office of Health Protection
Table A-11 FY91 Budget Summary
($ Thousands)

Appropriation

	GRF	Pesticide Control	Metabolic Screening	Water Permit	School Asbestos	Used Tire Mgnt	MCH	PHS	MCH Block	PHHS Block	TOTAL
Office of the Associate Director	520.2										520.2
Infectious Diseases	8,573.3							15,126.8	553.1		24,253.2
Food, Drugs and Dairies	2,030.2									208.8	2,239.0
Environmental Health	3,669.1	144.8		575.0	400.0	270.4		773.5			5,832.8
Epidemiologic Studies	820.4							76.5			896.9
Laboratories	4,178.6		1,384.3				110.0	109.9			5,782.8
TOTAL	19,791.8	144.8	1,384.3	575.0	400.0	270.4	110.0	16,086.7	553.1	208.8	39,524.9

Actual Expenditures

	GRF	Pesticide Control	Metabolic Screening	Water Permit	School Asbestos	Used Tire Mgnt	MCH	PHS	MCH Block	PHHS Block	TOTAL
Office of the Associate Director	600.2										600.2
Infectious Diseases	8,573.3							5,049.9	5.6		13,628.8
Food, Drugs and Dairies	2,109.5									95.4	2,204.9
Environmental Health	3,117.0	144.6		546.6	170.3	262.1		253.0			4,493.6
Epidemiologic Studies	820.4										820.4
Laboratories	4,004.0		1,183.2				108.2	99.6			5,395.0
TOTAL	19,224.4	144.6	1,183.2	546.6	170.3	262.1	108.2	5,402.5	5.6	95.4	27,142.9

Office of Health Protection
Table A-12 FY90 Budget Summary
($ Thousands)

Appropriation

	GRF	Pesticide Control	Metabolic Screening	Water Permit	School Asbestos	Used Tire Mgnt	MCH	PHS	MCH Block	PHHS Block	TOTAL
Office of the Associate Director	565.8										565.8
Infectious Diseases	8,545.5							10,432.2	509.7		19,487.4
Food, Drugs and Dairies	2,042.8									200.8	2,243.6
Environmental Health	3,578.9	139.2		472.5	125.0	260.0		293.1			4,868.7
Epidemiologic Studies	813.8										813.8
Laboratories	4,309.3		770.5				257.5	112.6			5,449.9
TOTAL	19,856.1	139.2	770.5	472.5	125.0	260.0	257.5	10,837.9	509.7	200.8	33,429.2

Actual Expenditures

	GRF	Pesticide Control	Metabolic Screening	Water Permit	School Asbestos	Used Tire Mgnt	MCH	PHS	MCH Block	PHHS Block	TOTAL
Office of the Associate Director	557.2										557.2
Infectious Diseases	7,881.8							5,961.8	446.9		14,290.5
Food, Drugs and Dairies	2,038.9									146.1	2,185.0
Environmental Health	3,553.4	139.1		457.4	45.5	166.6		254.8			4,616.8
Epidemiologic Studies	814.0										814.0
Laboratories	4,151.0		762.6				253.1	92.2			5,258.9
TOTAL	18,996.3	139.1	762.6	457.4	45.5	166.6	253.1	6,308.8	446.9	146.1	27,722.4

Office of Health Care Regulation
Table A-13 FY95 Budget Summary
($ thousands)

Appropriation Request

	GRF	Reg Eval Fund	LTC Monitor	Trauma Center	PHHS Block	PHS	TOTAL
Office of the Deputy Director	966.3						966.3
Bureau of Long Term Care	365.6		350.0				715.6
Administrative Rules and Procedures	108.1						108.1
LTC - Quality Assurance	1,240.4					575.0	1,815.4
LTC - Field Operations	7,434.9		400.0			3,750.0	11,584.9
Emergency Medical Services	1,212.3			2,500.0	50.0	80.0	3,842.3
HCR - Public Services	930.1						930.1
Health Care Facilities and Programs	1,041.7	75.0				2,313.2	3,429.9
TOTAL	13,299.4	75.0	750.0	2,500.0	50.0	6,718.2	23,392.6

Projected Expenditures

	GRF	Reg Eval Fund	LTC Monitor	Trauma Center	PHHS Block	PHS	TOTAL
Office of the Deputy Director	966.3						966.3
Bureau of Long Term Care	365.6		350.0				715.6
Administrative Rules and Procedures	108.1						108.1
LTC - Quality Assurance	1,190.4					575.0	1,765.4
LTC - Field Operations	7,335.5		400.0			3,750.0	11,485.5
Emergency Medical Services	1,162.3			2,500.0	50.0	80.0	3,792.3
HCR - Public Services	930.1						930.1
Health Care Facilities and Programs	1,041.7	75.0				2,246.0	3,362.7
TOTAL	13,100.0	75.0	750.0	2,500.0	50.0	6,651.0	23,126.0

Office of Health Care Regulation
Table A-14 FY94 Budget Summary
($ thousands)

Appropriation

	GRF	Reg Eval Fund	LTC Monitor	Trauma Center	PHHS Block	PHS	TOTAL
Office of the Deputy Director	966.3						966.3
Bureau of Long Term Care	365.6		350.0				715.6
Administrative Rules and Procedures	108.1						108.1
LTC - Quality Assurance	1,090.4					575.0	1,665.4
LTC - Field Operations	7,292.7		400.0			3,750.0	11,442.7
Emergency Medical Services	1,062.3			2,500.0	50.0	80.0	3,692.3
HCR - Public Services[1]	930.1						930.1
Health Care Facilities and Programs	1,041.7	75.0				3,316.4	4,433.1
TOTAL	12,857.2	75.0	750.0	2,500.0	50.0	7,721.4	23,953.6

Estimated Expenditures

	GRF	Reg Eval Fund	LTC Monitor	Trauma Center	PHHS Block	PHS	TOTAL
Office of the Deputy Director	966.3						966.3
Bureau of Long Term Care	365.6		350.0				715.6
Administrative Rules and Procedures	108.1						108.1
LTC - Quality Assurance	1,090.4					575.0	1,665.4
LTC - Field Operations	7,230.0		400.0			3,250.0	10,880.0
Emergency Medical Services	1,062.3			2,500.0	50.0	80.0	3,692.3
HCR - Public Services[1]	1,019.5						1,019.5
Health Care Facilities and Programs	1,041.7	25.0				2,526.4	3,593.1
TOTAL	12,883.9	25.0	750.0	2,500.0	50.0	6,431.4	22,640.3

[1]For FY94: The Divisions of LTC Information and Research and Alcohol and Substance Abuse have been reorganized into one Division.
NOTE: In FY94 the Division of Administration and Technical Support has been eliminated.

Office of Health Care Regulation
Table A-15 FY93 Budget Summary
($ thousands)

Appropriation

	GRF	State Project	LTC Monitor	PHS	TOTAL
Office of the Deputy Director	118.3				118.3
Bureau of Long Term Care	365.6		500.0		865.6
Administrative Rules and Procedures	108.1				108.1
LTC - Quality Assurance	1,090.4			547.0	1,637.4
LTC - Field Operations	7,012.3			3,257.2	10,269.5
Emergency Medical Services	1,062.3	14.0		46.1	1,122.4
LTC - Information and Research	768.7				768.7
Alcohol and Substance Abuse	161.4				161.4
Administration and Technical Support	848.0				848.0
Health Care Facilities and Programs	1,041.7			4,759.2	5,800.9
TOTAL	12,576.8	14.0	500.0	8,609.5	21,700.3

Actual Expenditures

	GRF	State Project	LTC Monitor	PHS	TOTAL
Office of the Deputy Director	118.3				118.3
Bureau of Long Term Care	365.6		319.8		68[c]
Administrative Rules and Procedures	108.1				108.1
LTC - Quality Assurance	1,005.0			400.0	1,405.0
LTC - Field Operations	7,010.0			1,842.7	8,852.7
Emergency Medical Services	1,015.0			40.0	1,055.0
LTC - Information and Research	731.3				731.3
Alcohol and Substance Abuse	161.4				161.4
Administration and Technical Support	848.0				848.0
Health Care Facilities and Programs	849.9			3,315.7	4,165.6
TOTAL	12,212.6	0	319.8	5,598.4	18,130.8

Office of Health Care Regulation
Table A-16 FY92 Budget Summary
($ thousands)

Appropriation

	GRF	State Project	LTC Monitor	PHS	TOTAL
Office of the Associate Director	155.0				155.0
Bureau of Long Term Care	541.8		500.0		1,041.8
LTC - Quality Assurance	1,252.6			500.0	1,752.6
LTC - Field Operations	8,656.4			2,628.5	11,284.9
Emergency Medical Services	1,253.1	13.6			1,266.7
LTC - Information and Research	490.7				490.7
Alcohol and Substance Abuse[1]					
Administration and Technical Support	990.1				990.1
Health Care Facilities and Programs	1,082.6			1,850.0	2,932.6
TOTAL	14,422.3	13.6	500.0	4,978.5	19,914.4

Actual Expenditures

	GRF	State Project	LTC Monitor	PHS	TOTAL
Office of the Associate Director	112.8				112.8
Bureau of Long Term Care	536.2		44.0		580.2
LTC - Quality Assurance	1,249.1			484.1	1,733.2
LTC - Field Operations	7,583.3			2,619.8	10,203.1
Emergency Medical Services	1,231.4				1,231.4
LTC - Information and Research	489.5				489.5
Alcohol and Substance Abuse[1]					
Administration and Technical Support	811.1				811.1
Health Care Facilities and Programs	1,058.6			1,759.6	2,818.2
TOTAL	13,072.0	0	44.0	4,863.5	17,979.5

[1]Organizationally transferred to Health Care Regulations on July 1, 1991, but appropriation remained in Community Health for FY92.

Office of Health Care Regulation
Table A-17 FY91 Budget Summary
($ thousands)

Appropriation

	GRF	State Project	LTC Monitor	PHS	TOTAL
Office of the Associate Director	160.6				160.6
Bureau of Long Term Care	660.7		300.0		960.7
LTC - Quality Assurance	1,319.6			500.0	1,819.6
LTC - Field Operations	7,904.1			2,500.0	10,404.1
Emergency Medical Services	6,165.6	13.0			6,178.6
LTC - Information and Research	476.4				476.4
Administration and Technical Support	925.6				925.6
Health Care Facilities and Programs	1,513.1			2,100.0	3,613.1
TOTAL	19,125.7	13.0	300.0	5,100.0	24,538.7

Actual Expenditures

	GRF	State Project	LTC Monitor	PHS	TOTAL
Office of the Associate Director	160.6				160.6
Bureau of Long Term Care	660.7		210.0		870.7
LTC - Quality Assurance	1,319.6			427.7	1,747.3
LTC - Field Operations	7,155.5			1,586.5	8,742.0
Emergency Medical Services	6,165.6				6,165.6
LTC - Information and Research	476.4				476.4
Administration and Technical Support	925.6				925.6
Health Care Facilities and Programs	1,327.4			965.6	2,293.0
TOTAL	18,191.4	0	210.0	2,979.8	21,381.2

Office of Health Care Regulation
Table A-18 FY90 Budget Summary
($ thousands)

Appropriation

	GRF	PHS	TOTAL
Office of the Associate Director	174.1		174.1
Bureau of Long Term Care	167.0		167.0
LTC - Quality Assurance	1,230.7	387.0	1,617.7
LTC - Field Operations	6,451.2	1,400.5	7,851.7
LTC - Information and Research	641.3		641.3
Administration and Technical Support	912.0		912.0
Health Care Facilities and Programs	1,073.3	897.7	1,971.0
TOTAL	10,649.6	2,685.2	13,334.8

Actual Expenditures

	GRF	PHS	TOTAL
Office of the Associate Director	174.0		174.0
Bureau of Long Term Care	165.0		165.0
LTC - Quality Assurance	1,228.1	361.8	1,589.9
LTC - Field Operations	6,437.8	1,166.0	7,603.8
LTC - Information and Research	637.1		637.1
Administration and Technical Support	882.8		882.8
Health Care Facilities and Programs	1,070.9	824.3	1,895.2
TOTAL	10,595.7	2,352.1	12,947.8

Office of Epidemiology and Health Systems Development
Table A-19 FY 95 Budget Summary
($ thousands)

Appropriation Request

	GRF	IHFP[1] Fund	Reg Eval Fund	PHS Fund	Fed Project	PHHS Block	TOTAL
Office of the Deputy Director	389.0	63.0				25.0	477.0
Health Policy	375.0					250.0	625.0
Epidemiologic Studies	800.7			1,275.0	400.0		2,475.7
Facilities Development	4.5	1,686.0	30.0				1,720.5
Illinois Center Health Statistics	275.0	51.0					326.0
TOTAL	1,844.2	1,800.0	30.0	1,275.0	400.0	275.0	5,624.2

Projected Expenditures

	GRF	IHFP[1] Fund	Reg Eval Fund	PHS Fund	Fed Project	PHHS Block	TOTAL
Office of the Deputy Director	382.0	63.0				25.0	470.0
Health Policy	370.0					250.0	620.0
Epidemiologic Studies	790.0			1,275.0	400.0		2,465.0
Facilities Development	4.5	1,686.4	30.0				1,720.5
Illinois Center Health Statistics	270.0	51.0					321.0
TOTAL	1,816.5	1,800.0	30.0	1,275.0	400.0	275.0	5,596.5

[1] Illinois Health Facilities Planning Fund.

Office of Epidemiology and Health Systems Development
Table A-20 FY 94 Budget Summary
($ thousands)

Appropriation

	GRF	IHFP[1] Fund	Reg Eval Fund	PHS Fund	Fed Project	PHHS Block	TOTAL
Office of the Deputy Director	366.0	55.7				250.0	671.7
Health Policy	274.6						274.6
Epidemiologic Studies	739.7			485.0	250.0		1,474.7
Facilities Development	4.5	1,495.4	30.0				1,529.9
Illinois Center Health Statistics	253.2	48.9					302.1
TOTAL	1,638.0	1,600.0	30.0	485.0	250.0	250.0	4,253.0

Estimated Expenditures

	GRF	IHFP[1] Fund	Reg Eval Fund	PHS Fund	Fed Project	PHHS Block	TOTAL
Office of the Deputy Director	358.1	55.7				250.0	663.8
Health Policy	274.6						274.6
Epidemiologic Studies	739.7			485.0	250.0		1,474.7
Facilities Development	4.5	1,495.4	10.1				1,509.9
Illinois Center Health Statistics	253.2	48.9					302.1
TOTAL	1,630.1	1,600.0	10.1	485.0	250.0	250.0	4,225.1

[1] Illinois Health Facilities Planning Fund.

Office of Epidemiology and Health Systems Development[1]
Table A-21 FY 93 Budget Summary
($ thousands)

Appropriation

	GRF	IHFP[3] Fund	PHS Fund	TOTAL
Office of the Deputy Director	236.3	50.0		286.3
Health Policy[2]	262.7			262.7
Epidemiologic Studies	705.9		136.0	841.9
Facilities Development	3.5	1,089.2		1,092.7
Illinois Center Health Statistics	266.1	45.8		311.9
TOTAL	1,474.5	1,185.0	136.0	2,795.5

Actual Expenditures

	GRF	IHFP[3] Fund	PHS Fund	TOTAL
Office of the Deputy Director	220.3	47.5		267.8
Health Policy[2]	257.4			257.4
Epidemiologic Studies	680.7		46.3	727.0
Facilities Development	3.4	979.2		982.6
Illinois Center Health Statistics[2]	262.3	45.8		308.1
TOTAL	1,424.1	1,072.5	46.3	2,542.9

[1] The Office name was changed from Office of Health Statistics, Policy and Planning in FY 93.
[2] The Division of Health Statistics and Policy Development was separated into the Division of Health Policy and the Illinois Center for Health Statistics in the FY93 reorganization of the Office.
[3] Illinois Health Facilities Planning Fund.

Office of Health Statistics, Policy and Planning
Table A-22 FY 92 Budget Summary
($ thousands)

Appropriation

	GRF	IHFP[1] Fund	State Project	TOTAL
Office of the Associate Director	282.7	150.0		432.7
Health Statistics and Policy Development	645.6		35.0	680.6
Epidemiologic Studies[2]				
Facilities Development	306.3	693.0		999.3
TOTAL	1,234.6	843.0	35.0	2,112.6

Actual Expenditures

	GRF	IHFP[1] Fund	State Project	TOTAL
Office of the Associate Director	206.5	84.8		291.3
Health Statistics and Policy Development	622.1		30.5	652.6
Epidemiologic Studies[2]				
Facilities Development	291.9	594.7		886.6
TOTAL	1,120.5	679.5	30.5	1,830.5

[1] Illinois Health Facilities Planning Fund.
[2] The Division of Epidemiologic Studies was organizationally transferred to the Office in May, 1991. The funds, however, remained in the Office of Health Protection.

Office of Health Policy and Planning
Table A-23 FY 91 Budget Summary
($ thousands)

Appropriation

	GRF	IHFP[1] Fund	TOTAL
Office of the Associate Director	200.2	171.7	371.9
Health Statistics and Policy Development[2]	757.7		757.7
Facilities Development	242.3	635.0	877.3
TOTAL	1,200.2	806.7	2,006.9

Actual Expenditures

	GRF	IHFP[1] Fund	TOTAL
Office of the Associate Director	196.0	168.4	364.4
Health Statistics and Policy Development[2]	747.0		747.0
Facilities Development	239.2	592.8	832.0
TOTAL	1,182.2	761.2	1,943.4

[1] Illinois Health Facilities Planning Fund.
[2] The Division of Health Policy and Finance and Health Information and Evaluation were combined to form one Division in the October, 1989 reorganization of the Office.

Office of Health Policy and Planning
Table A-24 FY 90 Budget Summary
($ thousands)

Appropriation

	GRF	IHFP[1] Fund	TOTAL
Office of the Associate Director	209.7	78.6	288.3
Health Policy and Finance	285.2	50.0	335.2
Facilities Development	177.5	526.9	704.4
Health Information and Evaluation	378.0		378.0
TOTAL	1,050.4	655.5	1,705.9

Actual Expenditures

	GRF	IHFP[1] Fund	TOTAL
Office of the Associate Director	209.0	68.9	277.9
Health Policy and Finance	283.1	47.3	330.4
Facilities Development	177.3	476.7	654.0
Health Information and Evaluation	377.0		377.0
TOTAL	1,046.4	592.9	1,639.3

[1] Illinois Health Facilities Planning Fund.

Office of Finance and Administration
Table A-25 FY 95 Budget Summary
($ thousands)

Appropriation Request

	GRF	PHS	Lead Posnig	WIC	MCH Block	Met Scrnig	PHHS Block	TOTAL
Office of the Deputy Director	4,797.5		40.0	100.0	10.0	50.0	5.0	4,952.5
Financial Services	863.2							913.2
Vital Records	1,338.5	300.0						1,638.5
Data Processing	3,197.9	300.0		1,291.5	200.0			4,989.4
Personnel and Business Services	5,424.0	380.4						5,804.4
TOTAL	15,621.1	980.4	40.0	1,391.5	210.0	50.0	5.0	18,298.0

Projected Expenditures

	GRF	PHS	Lead Posnig	WIC	MCH Block	Met Scrnig	PHHS Block	TOTAL
Office of the Deputy Director	4,725.5		40.0	100.0	10.0		5.0	4,880.5
Financial Services	850.3					50.0		900.3
Vital Records	1,318.4	291.6						1,610.0
Data Processing	3,149.9	291.5		1,276.1	200.0			4,917.5
Personnel and Business Services	5,342.5	373.4						5,715.9
TOTAL	15,386.6	956.5	40.0	1,376.1	210.0	50.0	5.0	18,024.2

Office of Finance and Administration
Table A-26 FY 94 Budget Summary
($ thousands)

Appropriation

	GRF	PHS	Lead Poison	WIC	MCH Block	PHHS Block	TOTAL
Office of the Deputy Director	4,566.0	222.3	40.0	100.0	10.0	5.0	4,943.3
Financial Services	821.5						821.5
Vital Records	1,273.9	250.0					1,523.9
Data Processing	3,043.6	150.0		1,323.6			4,517.2
Personnel and Business Services	5,162.3	33.0					5,195.3
TOTAL	14,867.3	655.3	40.0	1,423.6	10.0	5.0	17,001.2

Estimated Expenditures

	GRF	PHS	Lead Poison	WIC	MCH Block	PHHS Block	TOTAL
Office of the Deputy Director	4,632.9	222.3	40.0	100.0	10.0	5.0	5,010.2
Financial Services	821.5						821.5
Vital Records	1,273.9	250.0					1,523.9
Data Processing	3,043.6	150.0		1,188.7			4,382.3
Personnel and Business Services	5,162.3	33.0					5,195.3
TOTAL	14,934.2	655.3	40.0	1,288.7	10.0	5.0	16,933.2

Office of Finance and Administration
Table A-27 FY 93 Budget Summary
($ thousands)

Appropriation

	GRF	PHS	WIC	MCH Block	PHHS Block	TOTAL
Office of the Deputy Director	2,458.4	19.9	100.0	10.0	5.0	2,593.3
Financial Services	1,843.3					1,184.3
Vital Records	1,533.2	179.0				1,712.2
Local Health	2,461.4	301.0				2,762.4
Data Processing	2,716.9		1,551.9			4,268.8
Personnel and Business Services	5,382.7	45.0				5,427.7
TOTAL	15,736.9	544.9	1,651.9	10.0	5.0	17,948.7

Actual Expenditures

	GRF	PHS	WIC	MCH Block	PHHS Block	TOTAL
Office of the Deputy Director	2,405.6		17.7			2,423.3
Financial Services	1,151.1					1,151.1
Vital Records	1,503.9	176.6				1,680.5
Local Health	2,414.8	171.4				2,586.2
Data Processing	2,715.2		1,079.0			3,794.2
Personnel and Business Services	5,368.3	130.5				5,498.8
TOTAL	15,558.9	478.5	1,096.7			17,134.1

Office of Finance and Administration
Table A-28 FY 92 Budget Summary
($ thousands)

Appropriation

	GRF	PHS	Immig	WIC	MCH Block	PHHS Block	TOTAL
Office of the Associate Director	968.5	421.1	4,975.7	100.0	10.0	5.0	6,480.3
Financial Services	1,102.4						1,102.4
Vital Records	1,808.5	94.5					1,903.0
Local Health	9,529.1	410.4	24.3				9,963.8
Data Processing	3,100.4			1,501.1			4,601.5
Personnel and Business Services	5,625.0	71.4					5,696.4
Regional Operations	2,487.7						2,487.7
TOTAL	24,621.6	997.4	5,000.1	1,601.1	10.0	5.0	32,235.1

Actual Expenditures

	GRF	PHS	Immig	WIC	MCH Block	PHHS Block	TOTAL
Office of the Associate Director	363.3	46.0	1,832.9	9.5			2,251.7
Financial Services	1,102.4						1,102.4
Vital Records	1,808.5	94.5					1,903.0
Local Health	9,323.6	410.4	24.3				9,758.3
Data Processing	2,988.3			1,295.7			4,284.0
Personnel and Business Services	5,625.0	71.4					5,696.4
Regional Operations	2,487.7						2,497.7
TOTAL	23,708.8	622.3	1,857.2	1,305.2	0	0	27,493.5

Office of Finance and Administration
Table A-29 FY 91 Budget Summary
($ thousands)

Appropriation

	GRF	Immig	PHS	WIC	MCH Block	PHHS Block	TOTAL
Office of the Associate Director	3,115.8						3,115.8
Financial Services	1,234.4		10.0	100.0	10.0	5.0	1,359.4
Vital Records	1,618.8		200.0				1,818.8
Local Health	9,783.0	7,011.6	579.5				17,374.1
Data Processing	3,313.5			1,639.5			4,953.0
General Services	5,073.5		141.4				5,214.9
Personnel and Business Services	307.8						307.8
TOTAL	24,446.8	7,011.6	930.9	1,739.5	10.0	5.0	34,143.8

Actual Expenditures

	GRF	Immig	PHS	WIC	MCH Block	PHHS Block	TOTAL
Office of the Associate Director	3,099.8						3,009.8
Financial Services	1,225.6			4.0			1,229.6
Vital Records	1,612.7		92.4				1,705.1
Local Health	9,132.7	2,392.4	391.0				11,916.1
Data Processing	3,309.5			1,215.7			4,525.2
General Services	5,069.1		55.8				5,124.9
Personnel and Business Services	306.4						306.4
TOTAL	23,755.8	2,392.4	539.2	1,219.7	0	0	27,907.1

Office of Finance and Administration
Table A-30 FY 90 Budget Summary
($ thousands)

Appropriation

	GRF	Immig	Educ Asst	PHS	WIC	MCH Block	PHHS Block	TOTAL
Office of the Associate Director	2,722.7							2,722.7
Financial Services	1,145.6					7.5	5.0	1,158.1
Vital Records	1,551.2			100.0				1,651.2
Local Health	13,275.2	3,364.3		618.8				17,258.3
Data Processing	3,041.4				1,507.5			4,548.9
General Services	5,104.2			60.7				5,164.9
Personnel and Labor Relations	269.8							269.8
Center for Rural Health			400.0					400.0
TOTAL	27,110.1	3,364.3	400.0	779.5	1,507.5	7.5	5.0	33,173.9

Actual Expenditures

	GRF	Immig	Educ. Asst.	PHS	WIC	MCH Block	PHHS Block	TOTAL
Office of the Associate Director	2,665.0							2,665.0
Financial Services	1,044.6					7.2		1,051.8
Vital Records	1,440.1			63.4				1,503.5
Local Health	13,111.0	685.9		324.4				14,121.3
Data Processing	2,964.3				1,267.6			4,231.9
General Services	5,089.7			55.2				5,144.9
Personnel and Labor Relations	268.6							268.6
Center for Rural Health			389.6					389.6
TOTAL	26,583.3	685.9	389.6	443.0	1,267.6	7.2	0	29,376.6

Office of the Director
Table A-31 FY 95 Budget Summary
($ thousands)

Appropriation Request

	GRF	Educ Asst	PHS	Comm Hlth Care Cntr	Nurse Ded/Prof	WIC	PHHS Block	Podiatry Disciplin	Rural Access	TOTAL
Office of the Director	416.8									416.8
Legal Services	855.6									855.6
Governmental Affairs	274.2									274.2
Audits	241.8					150.0	25.0			416.8
Communications	230.9									230.0
Center for Rural Health	4,385.0	420.0	1,375.0	900.0	285.0			65.0	150.0	7,580.0
Deputy Director	65.9									65.9
Hearing Review	109.7									109.7
TOTAL	6,579.0	420.0	1,375.0	900.0	285.0	150.0	25.0	65.0	150.0	9,949.0

Projected Expenditures

	GRF	Educ Asst	PHS	Comm Hlth Care Cntr	Nurse Ded/Prof	WIC	PHHS Block	Podiatry Disciplin	Rural Access	TOTAL
Office of the Director	410.6									410.6
Legal Services	842.8									842.8
Governmental Affairs	270.1									270.1
Audits	238.2					150.0	25.0			413.2
Communications	226.6									226.6
Center for Rural Health	4,319.2	420.0	1,375.0	900.0	285.0			65.0	150.0	7,514.2
Deputy Director	64.9									64.9
Hearing Review	108.1									108.1
TOTAL	6,480.5	420.0	1,375.0	900.0	285.0	150.0	25.0	65.0	150.0	9,850.5

Office of the Director
Table A-32 FY 94 Budget Summary
($ thousands)

Appropriation

	GRF	Educ Asst	PHS	Comm Hlth Care Center	Nurse Ded/Prof	WIC	PHHS Block	Podiatry Disciplin	TOTAL
Office of the Director	396.7								396.7
Legal Services	814.3								814.3
Governmental Affairs	261.0								261.0
Audits	230.1					200.0	25.0		455.1
Communications	218.9								218.9
Center for Rural Health	4,173.3	420.0	725.0	700.0	285.0			50.0	6,353.3
Deputy Director	62.6								62.6
Hearing Review	104.4								104.4
TOTAL	6,261.3	420.0	725.0	700.0	285.0	200.0	25.0	50.0	8,666.3

Estimated Expenditures

	GRF	Educ Asst	PHS	Comm Hlth Care Center	Nurse Ded/Prof	WIC	PHHS Block	Podiatry Disciplin	TOTAL
Office of the Director	396.7								396.7
Legal Services	814.3								814.3
Governmental Affairs	261.0								261.0
Audits	230.1					200.0	25.0		455.1
Communications	218.9								218.9
Center for Rural Health	4,173.3	420.0	725.0	700.0	285.0			50.0	6,353.3
Deputy Director	62.6								62.6
Hearing Review	104.4								104.4
TOTAL	6,261.3	420.0	725.0	700.0	285.0	200.0	25.0	50.0	8,666.3

Office of the Director
Table A-33 FY 93 Budget Summary
($ thousands)

Appropriation

	GRF	Educ Asst	PHS	Comm Hlth Care Center	Nurse Ded/Prof	WIC	PHHS Block	TOTAL
Office of the Director	550.9							550.9
Legal Services	636.9							636.9
Governmental Affairs	198.1							198.1
Audits	226.7					50.0	25.0	301.7
Communications	158.2							158.2
Center for Rural Health	940.9	420.0	675.0	250.0	250.0			2,535.9
Deputy Director	40.9							40.9
Hearing Review	90.7							90.7
TOTAL	2,843.3	420.0	675.0	250.0	250.0	50.0	25.0	4,513.3

Actual Expenditures

	GRF	Educ Asst	PHS	Comm Hlth Care Center	Nurse Ded/Prof	WIC	PHHS Block	TOTAL
Office of the Director	490.2							490.2
Legal Services	636.7							636.7
Governmental Affairs	198.1							198.1
Audits	226.5					47.6	0	274.1
Communications	157.8							157.8
Center for Rural Health	923.8	418.2	360.6		240.8			1,177.4
Deputy Director	40.4							40.4
Hearing Review	90.5							90.5
TOTAL	2,764.0	418.2	360.6	0	240.8	47.6	0	3,065.2

Office of the Director
Table A-34 FY 92 Budget Summary
($ thousands)

Appropriation

	GRF	Educ Asst	MCH	PHS	Comm Hlth Care Center	School Asbestos	Illinois Hlth Fac	Water Permit	Used Tire Mgmt	Pest Control	WIC	Federal Projects	MCH Block	PHHS Block	Metabolic Screening	Hearing Aid	TOTAL
Office of the Director	1,548.2		0.7	233.7		3.9	8.1	8.4	2.9	2.5	43.0	0.5	17.0	28.6	15.2	0.8	1,913.5
Legal Services	725.7																725.7
Governmental Affairs	238.0																238.0
Audits	288.6																288.6
Communications	228.1																228.1
Center for Rural Health	3,872.8	420.0		291.5	62.5												4,646.8
Deputy Director	187.8																187.8
Hearing Review	71.6																71.6
TOTAL	7,160.8	420.0	0.7	525.2	62.5	3.9	8.1	8.4	2.9	2.5	43.0	0.5	17.0	28.6	15.2	0.8	8,300.1

Acutal Expenditures

	GRF	Educ Asst	MCH	PHS	Comm Hlth Care Center	School Asbestos	Illinois Hlth Fac	Water Permit	Used Tire Mgmt	Pest Control	WIC	Federal Projects	MCH Block	PHHS Block	Metabolic Screening	Hearing Aid	TOTAL
Office of the Director	1,034.4		0.6	108.6		3.7	6.0	2.1	0.8	1.5	39.8		14.4	3.5	14.4	0.8	1,230.6
Legal Services	725.7																725.7
Governmental Affairs	238.0																238.0
Audits	288.6																288.6
Communications	228.1																228.1
Center for Rural Health	3,872.8	407.3		291.5	60.3												4,631.9
Deputy Director	187.8																187.8
Hearing Review	71.6																71.6
TOTAL	6,647.0	407.3	0.6	400.1	60.3	3.7	6.0	2.1	0.8	1.5	39.8	0	14.4	3.5	14.4	0.8	7,602.3

Office of the Director
Table A-35 FY 91 Budget Summary
($ thousands)

Appropriation

	GRF	Comm Hlth Care Center	Educ Asst	PHS	PHHS Block	TOTAL
Office of the Director	577.4		420.0			997.4
Legal Services	868.9					868.9
Governmental Affairs	247.1					247.1
Audits	273.9				94.8	368.7
Communications	234.8					234.8
Center for Rural Health	4,069.6	62.5		274.4		4,406.5
Deputy Director	172.1					172.1
TOTAL	6,443.8	62.5	420.0	274.4	94.8	7,295.5

Actual Expenditures

	GRF	Comm Hlth Care Center	Educ Asst	PHS	PHHS Block	TOTAL
Office of the Director	538.8		410.7			949.5
Legal Services	857.9					857.9
Governmental Affairs	245.5					245.5
Audits	272.7					272.7
Communications	222.1					222.1
Center for Rural Health	4,027.8			101.7		4,129.5
Deputy Director	161.2					161.2
TOTAL	6,326.0	0	410.7	101.7	0	6,838.4

Office of the Director
Table A-36 FY 90 Budget Summary
($ thousands)

Appropriation

	GRF	Educ Asst	PPHS Block	TOTAL
Office of the Director	511.1			511.1
Legal Services	846.1			846.1
Govenmental Affairs	240.5			240.5
Audits	280.2	91.2		371.4
Communications	228.0			228.0
Center for Rural Health	225.0			225.0
Deputy Director	168.4			168.4
TOTAL	2,499.3	0	91.2	2,590.5

Actual Expenditures

	GRF	Educ Asst	PPHS Block	TOTAL
Office of the Director	476.9			476.9
Legal Services	835.4			835.4
Govenmental Affairs	238.9			238.9
Audits	279.0		30.0	309.0
Communications	215.7			215.7
Center for Rural Health	206.1			206.1
Deputy Director	153.1			153.1
TOTAL	2,405.1	0	30.0	2,435.1

Illinois Department of Public Health

Table A-37 FY90 through FY95 Budget Summary
By Office, By Fund
($ thousands)

FY 95 APPROPRIATION REQUEST

	STATE FUNDS																									FEDERAL FUNDS						Total All Funds
OFFICE	GRF	State Proj	Pest Cont	Hear Aid	Metab Screen	Alzhm Dis	Water Perm	Il Hlth Facil	Immigr	Schl Asbes	Used Tire	Educ Asst	Comm Hlth	Nurs D Prf	Tan Facil	Plumb Licen	Lab Revol	LTC Moni	Podi Disc	Reg Eval	Traum Cent	Fd/Drg Safety	Rural Accss	Sexual Asslt	Breast Cerv	Adt/Pd AIDS	Lead Pois	MCH	PHS	WIC	Fed Proj	MCH Block	PHHS Block	
Comm. Health	34,011.5	233.0		110.0	2,031.9	200.0			1,000.0															75.0	350.0		1,937.9	628.4	24,452.0	198,157.1	207.0	53,571.8	8,203.5	325,169.1
Health Protection	35,693.2		230.0		2,100.0		300.0			550.0	450.0				500.0	800.0	900.0					150.0				150.0	1,280.0		30,585.5			500.0		74,188.7
Health Care Reg.	13,299.4																	750.0		75.0	2,500.0							6,718.2				50.0	23,392.6
Epi. & Hlth Sys Dev	1,844.2							1,800.0												30.0								1,275.0		400.0		275.0	5,624.2
Admin. Support **	22,200.1				50.0							420.0	900.0	285.0					65.0				150.0				40.0	2,355.4	1,541.5		210.0	30.0	28,247.0
TOTAL	107,048.4	233.0	230.0	110.0	4,181.9	200.0	300.0	1,800.0	1,000.0	550.0	450.0	420.0	900.0	285.0	500.0	800.0	900.0	750.0	65.0	105.0	2,500.0	150.0	150.0	75.0	350.0	150.0	3,257.9	628.4	65,386.1	199,698.6	607.0	54,281.8	8,558.5	456,621.5

FY 95 PROJECTED EXPENDITURES

	STATE FUNDS																									FEDERAL FUNDS						Total All Funds
OFFICE	GRF	State Proj	Pest Cont	Hear Aid	Metab Screen	Alzhm Dis	Water Perm	Il Hlth Facil	Immigr	Schl Asbes	Used Tire	Educ Asst	Comm Hlth	Nurs D Prf	Tan Facil	Plumb Licen	Lab Revol	LTC Moni	Podi Disc	Reg Eval	Traum Cent	Fd/Drg Safety	Rural Accss	Sexual Asslt	Breast Cerv	Adt/Pd AIDS	Lead Pois	MCH	PHS	WIC	Fed Proj	MCH Block	PHHS Block	
Comm. Health	33,501.3	233.0		110.0	2,031.9	200.0			1,000.0															75.0	350.0		1,937.9	628.4	24,207.5	197,166.3	207.0	53,036.1	8,121.5	322,805.9
Health Protection	35,157.8		230.0		2,100.0		300.0			550.0	450.0				500.0	800.0	900.0					150.0				150.0	1,280.0		30,279.6			500.0		73,347.4
Health Care Reg.	13,100.0																	750.0		75.0	2,500.0							6,651.0				50.0	23,126.0
Epi. & Hlth Sys Dev	1,816.5							1,800.0												30.0								1,275.0		400.0		275.0	5,596.5
Admin. Support **	21,867.1				50.0							420.0	900.0	285.0					65.0				150.0				40.0	2,331.5	1,526.1		210.0	30.0	27,874.7
TOTAL	105,442.7	233.0	230.0	110.0	4,181.9	200.0	300.0	1,800.0	1,000.0	550.0	450.0	420.0	900.0	285.0	500.0	800.0	900.0	750.0	65.0	105.0	2,500.0	150.0	150.0	75.0	350.0	150.0	3,257.9	628.4	64,744.6	198,692.4	607.0	53,746.1	8,476.5	452,750.4

** FIGURES SHOWN IN THIS ROW INCLUDE FUNDING FOR THE DIRECTOR'S OFFICE

Illinois Department of Public Health

Table A-37 FY90 through FY95 Budget Summary
By Office, By Fund
($ thousands)

FY 94 APPROPRIATION

	STATE FUNDS																							FEDERAL FUNDS						Total All Funds
OFFICE	GRF	State Proj	Pest Cont	Hear Aid	Metab Screen	Alzhm Dis	Water Perm	Il Hlth Facil	Immigr	Schl Asbes	Used Tire	Educ Asst	Comm Hlth	Nurs D Prf	Tan Facil	Plumb Licen	Lab Revol	LTC Moni	Podi Disc	Reg Eval	Traum Cent	Fd/Drg Safety	Breast Cerv	Ryan White	Lead Pois	MCH	PHS	WIC	Fed Proj	MCH Block	PHHS Block	
Comm. Health	31,966.5	233.0		105.0	2,400.0	200.0			3,250.0														250.0		1,745.7	751.6	23,690.6	180,169.3	110.3	44,387.0	7,754.1	297,013.1
Health Protection	35,321.5		200.0		2,500.0		400.0			480.0	450.0				500.0	800.0	1,250.0					150.0		100.0	1,178.0		25,536.3			1,026.4		69,892.2
Health Care Reg.	12,857.2																	750.0		75.0	2,500.0						7,721.4				50.0	23,953.6
Epi & Hlth Sys Dev	1,638.0							1,600.0												30.0							485.0		250.0		250.0	4,253.0
Admin. Support **	21,128.6											420.0	700.0	285.0					50.0						40.0		1,380.3	1,623.6		10.0	30.0	25,667.5
TOTAL	102,911.8	233.0	200.0	105.0	4,900.0	200.0	400.0	1,600.0	3,250.0	480.0	450.0	420.0	700.0	285.0	500.0	800.0	1,250.0	750.0	50.0	105.0	2,500.0	150.0		100.0	2,963.7	751.6	58,813.6	181,792.9	360.3	45,423.4	8,084.1	420,779.3

FY 94 ESTIMATED EXPENDITURES

	STATE FUNDS																							FEDERAL FUNDS						Total All Funds
OFFICE	GRF	State Proj	Pest Cont	Hear Aid	Metab Screen	Alzhm Dis	Water Perm	Il Hlth Facil	Immigr	Schl Asbes	Used Tire	Educ Asst	Comm Hlth	Nurs D Prf	Tan Facil	Plumb Licen	Lab Revol	LTC Moni	Podi Disc	Reg Eval	Traum Cent	Fd/Drg Safety	Breast Cerv	Ryan White	Lead Pois	MCH	PHS	WIC	Fed Proj	MCH Block	PHHS Block	
Comm. Health	31,959.5	233.0		105.0	2,400.0	200.0			3,250.0														250.0		1,745.7	751.6	22,831.7	179,293.0	110.3	16,398.6	3,650.6	263,179.0
Health Protection	34,953.8		200.0		2,500.0		400.0			480.0	260.0				500.0	600.0	500.0					150.0		100.0	1,178.0		21,997.8			626.4		64,446.0
Health Care Reg.	12,883.9																	750.0		25.0	2,500.0						6,431.4				50.0	22,640.3
Epi & Hlth Sys Dev	1,630.1							1,600.0												10.0							485.0		250.0		250.0	4,225.1
Admin. Support **	21,195.5											420.0	700.0	285.0					50.0						40.0		1,380.3	1,488.7		10.0	30.0	25,599.5
TOTAL	102,622.8	233.0	200.0	105.0	4,900.0	200.0	400.0	1,600.0	3,250.0	480.0	260.0	420.0	700.0	285.0	500.0	600.0	500.0	750.0	50.0	35.0	2,500.0	150.0		100.0	2,963.7	751.6	53,126.2	180,781.7	360.3	17,035.0	3,980.6	380,089.8

** FIGURES SHOWN IN THIS ROW INCLUDE FUNDING FOR THE DIRECTOR'S OFFICE

Illinois Department of Public Health

Table A-37 FY90 through FY95 Budget Summary
By Office, By Fund
($ thousands)

FY 93 APPROPRIATION

	STATE FUNDS																		FEDERAL FUNDS						Total All Funds
OFFICE	GRF	State Proj	Pest Cont	Hear Aid	Metab Screen	Alzhm Dis	Water Perm	Il Hlth Facil	Immigr	Schl Asbes	Used Tire	Educ Asst	Comm Hlth	Nurs D Prf	Tan Facil	Plumb Licen	LTC Moni	Ryan White	Lead Pois	MCH	PHS	WIC	Fed Proj	MCH Block	PHHS Block	
Comm. Health	31,538.7	33.0		101.5	1,585.0	250.0			2,250.0										2,575.2	546.9	20,987.6	172,634.3	149.3	44,518.0	6,403.7	283,573.2
Health Protection	25,785.7		261.0		1,520.0		434.0			480.0	300.0				500.0	150.0		150.0	776.4		17,083.3			947.9	229.1	48,617.4
Health Care Reg.	12,576.8	14.0															500.0				8,609.5					21,700.3
Epi. & Hlth Sys Dev	1,474.5							1,185.0													136.0					2,795.5
Admin. Support **	18,580.2											420.0	250.0	250.0							1,219.9	1,701.9		10.0	30.0	22,462.0
TOTAL	89,955.9	47.0	261.0	101.5	3,105.0	250.0	434.0	1,185.0	2,250.0	480.0	300.0	420.0	250.0	250.0	500.0	150.0	500.0	150.0	3,351.6	546.9	48,036.3	174,336.2	149.3	45,475.9	6,662.8	379,148.4

FY 93 ACTUAL EXPENDITURES

	STATE FUNDS																		FEDERAL FUNDS						Total All Funds
OFFICE	GRF	State Proj	Pest Cont	Hear Aid	Metab Screen	Alzhm Dis	Water Perm	Il Hlth Facil	Immigr	Schl Asbes	Used Tire	Educ Asst	Comm Hlth	Nurs D Prf	Tan Facil	Plumb Licen	LTC Moni	Ryan White	Lead Pois	MCH	PHS	WIC	Fed Proj	MCH Block	PHHS Block	
Comm. Health	31,096.6	0.0		84.7	1,228.2	139.8			1,298.4										48.1	352.2	11,976.0	143,017.0	0.0	21,029.3	3,012.3	213,282.6
Health Protection	25,338.3		195.9		1,502.8		196.0			380.1	257.6				91.6	80.1		0.0	192.8		11,657.0			173.6	225.9	40,291.7
Health Care Reg.	12,212.6	0.0															319.8				5,598.4					18,130.8
Epi. & Hlth Sys Dev	1,424.1							1,072.5													46.3					2,542.9
Admin. Support **	18,322.9											418.2	0.0	240.8							839.1	1,144.3		0.0	0.0	20,965.3
TOTAL	88,394.5	0.0	195.9	84.7	2,731.0	139.8	196.0	1,072.5	1,298.4	380.1	257.6	418.2	0.0	240.8	91.6	80.1	319.8	0.0	240.9	352.2	30,116.8	144,161.3	0.0	21,202.9	3,238.2	295,213.3

** FIGURES SHOWN IN THIS ROW INCLUDE FUNDING FOR THE DIRECTOR'S OFFICE

Illinois Department of Public Health

Table A-37 FY90 through FY95 Budget Summary
By Office, By Fund
($ thousands)

FY 92 APPROPRIATION

	STATE FUNDS														FEDERAL FUNDS						Total All Funds
OFFICE	GRF	State Proj	Pest Cont	Hear Aid	Metab Screen	Alzhm Dis	Water Perm	Il Hlth Facil	Immigr	Schl Asbes	Used Tire	Educ Asst	Comm Hlth	LTC Moni	MCH	PHS	WIC	Fed Proj	MCH Block	PHHS Block	
Comm. Health	42,817.5	31.4		95.9	1,505.6	261.3									369.2	16,183.0	156,391.9	47.9	46,403.8	4,659.7	268,767.2
Health Protection	19,935.8		151.3		1,446.6		405.0			418.0	282.6				115.0	16,454.0			894.4	218.2	40,320.9
Health Care Reg.	14,422.3	13.6												500.0		4,978.5					19,914.4
Health Pol. & Plan	1,234.6	35.0						843.0													2,112.6
Admin. Support **	31,782.4		2.5	0.8	15.2		8.4	8.1	5,000.0	3.9	2.9	420.0	62.5		0.7	1,522.6	1,644.1	0.5	27.0	33.6	40,535.2
TOTAL	110,192.6	80.0	153.8	96.7	2,967.4	261.3	413.4	851.1	5,000.0	421.9	285.5	420.0	62.5	500.0	484.9	39,138.1	158,036.0	48.4	47,325.2	4,911.5	371,650.3

FY 92 ACTUAL EXPENDITURES

	STATE FUNDS														FEDERAL FUNDS						Total All Funds
OFFICE	GRF	State Proj	Pest Cont	Hear Aid	Metab Screen	Alzhm Dis	Water Perm	Il Hlth Facil	Immigr	Schl Asbes	Used Tire	Educ Asst	Comm Hlth	LTC Moni	MCH	PHS	WIC	Fed Proj	MCH Block	PHHS Block	
Comm. Health	40,344.6	3.8		67.3	776.8	154.5									268.6	10,610.4	132,930.4	0.0	20,628.9	1,804.7	207,590.0
Health Protection	19,056.4		151.3		1,391.4		275.4			350.1	231.4					8,757.5			346.4	108.6	30,668.5
Health Care Reg.	13,072.0	0.0												44.0		4,863.5					17,979.5
Health Pol. & Plan.	1,120.5	30.5						679.5													1,830.5
Admin. Support **	30,355.8		1.5	0.8	14.4		2.1	6.0	1,857.2	3.7	0.8	407.3	60.3		0.6	1,022.2	1,345.2	0.0	14.4	3.5	35,095.8
TOTAL	103,949.3	34.3	152.8	68.1	2,182.6	154.5	277.5	685.5	1,857.2	353.8	232.2	407.3	60.3	44.0	269.2	25,253.6	134,275.6	0.0	20,989.7	1,916.8	293,164.3

** FIGURES SHOWN IN THIS ROW INCLUDE FUNDING FOR THE DIRECTOR'S OFFICE

Illinois Department of Public Health

Table A-37 FY90 through FY95 Budget Summary
By Office, By Fund
($ thousands)

FY 91 APPROPRIATION

	STATE FUNDS														FEDERAL FUNDS						Total All Funds
OFFICE	GRF	State Proj	Pest Cont	Hear Aid	Metab Screen	Alzhm Dis	Water Perm	Il Hlth Facil	Immigr	Schl Asbes	Used Tire	Educ Asst	Comm Hlth	LTC Moni	MCH	PHS	WIC	Fed Proj	MCH Block	PHHS Block	
Health Services	40,182.2	55.0		91.8	1,366.6	250.0									681.9	11,708.7	134,051.7	45.8	43,875.6	3,606.2	235,915.5
Health Protection	19,791.8		144.8		1,384.3		575.0			400.0	270.4				110.0	16,086.7			553.1	208.8	39,524.9
Health Care Reg.	19,125.7	13.0												300.0		5,100.0					24,538.7
Health Pol. & Plan.	1,440.6	35.0						806.7													2,282.3
Admin. Support **	30,890.6								7,011.6			420.0	62.5			1,205.3	1,739.5		10.0	99.8	41,439.3
TOTAL	111,430.9	103.0	144.8	91.8	2,750.9	250.0	575.0	806.7	7,011.6	400.0	270.4	420.0	62.5	300.0	791.9	34,100.7	135,791.2	45.8	44,438.7	3,914.8	343,700.7

FY 91 ACTUAL EXPENDITURES

	STATE FUNDS														FEDERAL FUNDS						Total All Funds
OFFICE	GRF	State Proj	Pest Cont	Hear Aid	Metab Screen	Alzhm Dis	Water Perm	Il Hlth Facil	Immigr	Schl Asbes	Used Tire	Educ Asst	Comm Hlth	LTC Moni	MCH	PHS	WIC	Fed Proj	MCH Block	PHHS Block	
Health Services	39,405.3	47.2		68.7	543.4	141.4									246.2	9,836.6	122,632.5	34.1	18,988.6	1,735.1	193,678.8
Health Protection	19,224.4		144.6		1,183.2		546.6			170.3	262.1				108.2	5,402.5			5.6	95.4	27,142.9
Health Care Reg.	18,191.4	0.0												210.0		2,979.8					21,381.2
Health Pol. & Plan.	1,415.0	0.0						731.2													2,176.2
Admin. Support **	30,081.8								2,392.4			410.7	0.0			640.9	1,219.7		0.0	0.0	34,745.5
TOTAL	108,317.9	47.2	144.6	68.7	1,726.6	141.4	546.6	731.2	2,392.4	170.3	262.1	410.7	0.0	210.0	354.4	18,859.8	123,852.2	34.1	18,994.2	1,830.5	279,124.6

** FIGURES SHOWN IN THIS ROW INCLUDE FUNDING FOR THE DIRECTOR'S OFFICE

Illinois Department of Public Health

Table A-37 FY90 through FY95 Budget Summary
By Office, By Fund
($ thousands)

FY 90 APPROPRIATION

	STATE FUNDS												FEDERAL FUNDS						Total All Funds
OFFICE	ORF	State Proj	Pest Cont	Hear Aid	Metab Screen	Alzhm Dis	Water Perm	Il Hlth Facil	Immigr	Schl Asbes	Used Tire	Educ Asst	MCH	PHS	WIC	Fed Proj	MCH Block	PHHS Block	
Health Services	42,445.4	77.5		131.3		219.5							655.7	11,102.4	108,843.4	44.0	40,415.4	3,663.0	207,597.6
Health Protection	19,856.1		139.2		770.5		472.5			125.0	260.0		257.5	10,837.9			509.7	200.8	33,429.2
Health Care Reg.	10,649.6													2,685.2					13,334.8
Health Pol. & Plan.	1,050.4							655.5											1,705.9
Admin. Support **	29,609.4								3,364.3			400.0		779.5	1,507.5		7.5	96.2	35,764.4
TOTAL	103,610.9	77.5	139.2	131.3	770.5	219.5	472.5	655.5	3,364.3	125.0	260.0	400.0	913.2	25,405.0	110,350.9	44.0	40,932.6	3,960.0	291,831.9

FY 90 ACTUAL EXPENDITURES

	STATE FUNDS												FEDERAL FUNDS						Total All Funds
OFFICE	GRF	State Proj	Pest Cont	Hear Aid	Metab Screen	Alzhm Dis	Water Perm	Il Hlth Facil	Immigr	Schl Asbes	Used Tire	Educ Asst	MCH	PHS	WIC	Fed Proj	MCH Block	PHHS Block	
Health Services	40,700.8	47.9		59.6		196.2							197.2	9,308.9	103,637.0	43.6	21,863.8	1,978.7	178,033.7
Health Protection	18,996.3		139.1		762.6		457.4			45.5	166.6		253.1	6,308.8			446.9	146.1	27,722.4
Health Care Reg.	10,595.7													2,352.1					12,947.8
Health Pol. & Plan	1,046.4							592.9											1,639.3
Admin. Support **	28,988.4								685.9			389.6		443.0	1,267.6		7.2	30.0	31,811.7
TOTAL	100,327.6	47.9	139.1	59.6	762.6	196.2	457.4	592.9	685.9	45.5	166.6	389.6	450.3	18,412.8	104,904.6	43.6	22,317.9	2,154.8	252,154.9

** FIOURES SHOWN IN THIS ROW INCLUDE FUNDING FOR THE DIRECTOR'S OFFICE

OFFICES:

Admin. Support	Administrative Support
Comm. Health	Community Health
Epi. & Hlth Sys Dev	Epidemiology and Health Systems Development
Health Care Reg.	Health Care Regulation
Health Pol. & Plan.	Health Policy and Planning

FUNDING SOURCES:

Alzhm Dis	Alzheimer's Disease Research Fund
Comm Hlth	Community Health Center Care Fund
Educ Assist	Education Assistance Fund
Fd/Drg Safety	Food and Drug Safety Fund
Fed Proj	Public Health Federal Projects Fund
GRF	General Revenue Funds
Hear Aid	Hearing Aid Dispenser Examining and Certification Fund
Il Hlth Facil	Illinois Health Facilities Planning Fund
Immigr	Immigration Reform and Control Fund
Lab Revol	Laboratory Services Revolving Fund
Lead Pois	Lead Poisoning, Screening, Prevention and Abatement Fund
LTC Moni	Long-Term Care Monitor/Receiver Fund
MCH	Maternal and Child Health Services Fund
MCH Block	Maternal and Child Health Services Block Fund
Metab Screen	Metabolic Screening and Treatment Fund
Nurs D Prf	Nurse Dedicated and Professional Fund
Pest Cont	Pesticide Control Fund
PHHS Block	Preventative Health and Health Services Block Fund
PHS	Public Health Services Fund
Plumb Licen	Plumbing Licensure and Program Fund
Podi Disc	Podiatric Disciplinary Fund
Reg Eval	Basic Enforcement and Regulatory Evaluation Fund
Ryan White	Ryan White AIDS Victims Assistance Fund
Schl Asbes	Illinois School Asbestos Abatement Fund
State Proj	Public Health Special State Project Fund
Tan Facil	Tanning Facility Permit Fund
Traum Cent	Trauma Center Fund
Used Tire	Used Tire Management Fund
Water Perm	Public Health Water Permit Fund
WIC	Women, Infants and Children Fund

Source: Illinois State Budget Appendices: Fiscal Years 1990-1994

Refer to individual office tables for specific appropriation and expenditure information

APPENDIX II

Illinois Department of Public Health

Table A-38 Major Federal Funding Sources FY92

Federal Program Title	Administering Federal Agency	Federal Act	Public Law	Match
State-Based Diabetes Control Project	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 301(a)	P.L. 95-626 P.L. 95-224	
Food Inspection Program	Department of Health and Human Services (CDC)			
Disease Control Project Grant (Sexually Transmitted Diseases)	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 318, aa by the Communicable Disease Control Amendments of 1972 and 1976.	P.L. 92-449; P.L. 92-317; P.L. 95-626	
Disease Control Project Grant (Immunization)	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 317, aa by the Communicable Disease Control Amendments of 1972 and 1976.	P.L. 92-449; P.L. 94-317; P.L. 95-626	
Vital Records Component of Cooperative Health Statistics System	Department of Health and Human Services (CDC)			
State Health Care Providers Survey Certification	Department of Health and Human Services (HCFA)	Social Security Act of 1965, Title XVIII, Part A	P.L. 89-97 aa by P.L.S. 90-248, 92-603, 93-233, 94-182 and 94-437	

Illinois Department of Public Health
Table A-38 Major Federal Funding Sources FY92
(continued)

Federal Program Title	Administering Federal Agency	Federal Act	Public Law	Match
Special Supplemental Food Program for Women, Infants and Children	Department of Agriculture (Food and Nutrition Service)	Child Nutrition Act of 1966, Section 17	aa P.L. 92-433; aa P.L. 94-105 aa P.L. 95-627 P.L. 96-499 P.L. 98-473 P.L. 99-190 P.L. 99-500 P.L. 99-591	
Commodity Supplemental Food Program	Department of Agriculture (Food and Nutrition Services)	Agriculture and Consumer Protection Act of 1973; Food and Agriculture Act of 1977	aa P.L. 93-86 P.L. 95-113 97-98 98-92 99-198 99-500 99-591	
Pesticide Use and Marketing Enforcement	U.S. Environmental Protection Agency and Illinois Department of Agriculture	The Federal Insecticide, Fungicide, and Rodenticide Act, 7 U.S.C. 135, et. seq.	P.L. 92-516 aa P.L. 94-140 aa P.L. 95-396	15%
Health Programs for Refugees	Department of Health and Human Services (CDC)	Immigration and Nationality Act Section 412(c)(3)	P.L. 96-212 aa P.L. 97-363 P.L. 99-605	

Illinois Department of Public Health
Table A-38 Major Federal Funding Sources FY92
(continued)

Federal Program Title	Administering Federal Agency	Federal Act	Public Law	Match
Family Planning - Title X	Department of Health and Human Services (PHS)	Public Health Service Act, Title X, Section 1001	P.L. 95-613	Some. Federal funds cannot be 100%
TB Control Project	Department of Health and Human Services (CDC)	Public Health Services Act, Section 317	P.L. 97-35 aa P.L. 98-555	
Maternal and Child Health Block Grant	Department of Health and Human Services PHS, HRSA, Bureau of Maternal and Child Health Services	Social Security Act, Title V	P.L. 97-35	3/7 (42.86%)
Preventive Health and Health Services Block Grant	Department of Health and Human Services (CDC)	Public Health Services Act, Title XIX, Part A	P.L. 97-35 P.L. 98-555	
Behavioral Risk Factor Surveillance	Department of Health and Human Services (CDC)	Public Health Services Act 301(a)	P.L. 95-626 P.L. 97-35	
Procurement of Information for the National Death Index	Department of Health and Human Services (Office of Asst. Secretary for Health-NCHS)			

Illinois Department of Public Health
Table A-38 Major Federal Funding Sources FY92
(continued)

Federal Program Title	Administering Federal Agency	Federal Act	Public Law	Match
Product Hazard and Injury Information (Death Certificates)	Consumer Product and Safety Commission (Division of Hazard and Injury Data Systems)			
AIDS - Prevention and Surveillance	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 301(a)	P.L. 95-626aa	
AIDS - Seroprevalence Studies	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 301(a)	P.L. 95-626aa	
Cervical Cancer Prevention and Control	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 301(a)	P.L. 78-410aa P.L. 95-626aa P.L. 99-159	
Data Based Cancer Intervention	Department of Health and Human Services, National Cancer Institute (Research)	Public Health Services Act, Sec. 301(a)	P.L. 78-410aa P.L. 95-626aa P.L. 99-159	
Social Security Enumeration At Birth	Department of Health and Human Services (Social Security Administration)			
Drug Free Families with a Future	Department of Health and Human Services (ADAMHA, Office of Substance Abuse Prevention)	Public Health Services Act Sec. 509F and 509G	P.L. 100-690	

Illinois Department of Public Health
Table A-38 Major Federal Funding Sources FY92
(continued)

Federal Program Title	Administering Federal Agency	Federal Act	Public Law	Match
Pregnancy Nutrition Surveillance System	Department of Health and Human Services (CDC)	PHS Act 317(K)(3) and 301(A)	P.L. 95-626	
Planned Approach to Community Health	Department of Health and Human Services (CDC)			
Building State Capacity to Conduct Health Assessments	Department of Health and Human Services (ATSDR)	Sec. 104(I)(14)(15) of Comprehensive Environmental Response, Compensation, and Liability Act	P.L. 99-499aa P.L. 98-616	
Environmental Health Education for Physicians and Health Professionals	Department of Health and Human Services (ATSDR)	Sec. 104(I)(14)(15) of Comprehensive Environmental Response, Compensation, and Liability Act	P.L. 99-499 P.L. 98-616	
Laboratory Training Network	Department of Health and Human Services (CDC)	PHS Act Sec. 317(K)(3)	P.L. 95-626 P.L. 100-202	
Influenza Vaccine Demonstration	Department of Health and Human Services (HCFA)	Sec. 4071	P.L. 100-203	
Asbestos in Schools - AHERA Accreditation	U.S. Environmental Protection Agency - Office of Pesticides and Toxic Substances	Toxic Substance Control Sec. 28	P.L. 94-469	
State Office of Rural Health	Department of Health and Human Services (HCDA)	Public Health Services Act, Sec. 3385	P.L. 101-597	

Illinois Department of Public Health
Table A-38 Major Federal Funding Sources FY92
(continued)

Federal Program Title	Administering Federal Agency	Federal Act	Public Law	Match
Primary Health Care	Department of Health and Human Services (HCDA)	Public Health Services Act, Sec. 333 (D)	P.L. 100-170	
Prenatal Smoking Cessation	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 301	P.L. 100-202	
Illinois State and Community Based Child Lead Poisoning	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 301 and 317A	P.L. 100-572	
Healthy Start	Department of Health and Human Services (HRSA)	Public Health Services Act, Title III, Part A, Sec. 301		
Breastfeeding Promotion	Department of Health and Human Services (HRSA)	Socail Security Act, Title V, Sec. 502 (a)(1)		
Lead Exposure	Department of Health and Human Services (ATSDR)	Sec. 104(15) Comprehensive Environmental Response Compensation and Liability Act of 1980	P.L. 99-499, P.L. 98-616	
HIV CARE Grant/AIDS	Department of Health and Human Services (HRD)	Public Health Services Act, Ryan White CARE Act, Title II	P.L. 101-381	16 2/3%
Enhancement to Asbestos Training Requirements	U.S. Environmental Protection Agency	Toxic Substance Control Act, Sec. 28	P.L. 94-469	25%

Illinois Department of Public Health
Table A-38 Projected Major Federal Funding Sources FY92
(continued)

The Department of Public Health receives federal funds via other agencies as follows:

Department of Public Aid:
- Title XX
- Indo-Chinese Refugee Program
- Social Services Block - Parents Too Soon; Rape; Early Periodic Screening, Diagnosis and Treatment.
- Teen Parent Employment Training

Environmental Protection Agency:
- Federal Safe Drinking Water Act

Office of Education
- Summer Food Service Program
- Early Intervention for Infants and Toddlers

Abbreviations Used in Text:

ADAMHA	Alcohol, Drug Abuse and Mental Health Administration
AHERA	Asbestos Hazardous Emergency Response Act
ATSDR	Agency for Toxic Substances and Disease Registry
CDC	Centers for Disease Control
HCDA	Health Care Delivery and Assistance Bureau
HCFA	Health Care Financing Administration
HRD	Health Resources Development
HRSA	Health Resources and Services Administration
NCHS	National Center for Health Statistics
PHS	Public Health Service
aa	as amended

Illinois Department of Public Health

Table A-39 Major Federal Funding Sources FY93

Federal Program Title	Administering Federal Agency	Federal Act	Public Law	Match
State-Based Diabetes Control Project	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 301(a)	P.L. 95-626 P.L. 95-224	
Food Inspection Program	Department of Health and Human Services (CDC)			
Disease Control Project Grant (Sexually Transmitted Diseases)	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 318, aa by the Communicable Disease Control Amendments of 1972 and 1976.	P.L. 92-449; P.L. 92-317; P.L. 95-626	
Disease Control Project Grant (Immunization)	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 317, aa by the Communicable Disease Control Amendments of 1972 and 1976.	P.L. 92-449; P.L. 92-317; P.L. 95-626	
Vital Records Component of Cooperative Health Statistics System	Department of Health and Human Services (CDC)			
State Health Care Providers Survey Certification	Department of Health and Human Services (HCFA)	Social Security Act of 1965, Title XVIII, Part A	P.L. 89-97 aa by P.L.S. 90-248, 92-603, 93-233, 94-182 and 94-437	

Illinois Department of Public Health
Table A-39 Major Federal Funding Sources FY93
(continued)

Federal Program Title	Administering Federal Agency	Federal Act	Public Law	Match
Special Supplemental Food Program for Women, Infants and Children	Department of Agriculture (Food and Nutrition Service)	Child Nutrition Act of 1966, Section 17	aa P.L. 92-433; aa P.L. 94-105 aa P.L. 95-627 P.L. 96-499 P.L. 98-473 P.L. 99-190 P.L. 99-500 P.L. 99-591	
Commodity Supplemental Food Program	Department of Agriculture (Food and Nutrition Services)	Agriculture and Consumer Protection Act of 1973; Food and Agriculture Act of 1977	aa P.L. 93-86 P.L. 95-113 97-98 98-92 99-198 99-500 99-591	
Pesticide Use and Marketing Enforcement	U.S. Environmental Protection Agency and Illinois Department of Agriculture	The Federal Insecticide, Fungicide, and Rodenticide Act, 7 U.S.C. 135, et. seq.	P.L. 92-516 aa P.L. 94-140 aa P.L. 95-396	15%
Health Programs for Refugees	Department of Health and Human Services, (CDC)	Immigration and Nationality Act, Section 412(c)(3)	P.L. 96-212 aa P.L. 97-363 P.L. 99-605	

Illinois Department of Public Health
Table A-39 Major Federal Funding Sources FY93
(continued)

Federal Program Title	Administering Federal Agency	Federal Act	Public Law	Match
Family Planning - Title X	Department of Health and Human Services, (PHS)	Public Health Service Act, Title X, Section 1001	P.L. 95-613	Some. Federal funds cannot be 100%
TB Control Project	Department of Health and Human Services, (CDC)	Public Health Services Act, Section 317	P.L. 97-35 aa P.L. 98-555	
Maternal and Child Health Block Grant	Department of Health and Human Services PHS, HRSA, Bureau of Maternal and Child Health Services	Social Security Act, Title V	P.L. 97-35	3/7 (42.86%)
Preventive Health and Health Services Block Grant	Department of Health and Human Services (CDC)	Public Health Services Act, Title XIX, Part A	P.L. 97-35 P.L. 98-555	
Behavioral Risk Factor Surveillance	Department of Health and Human Services (CDC)	Public Health Services Act 301(a)	P.L. 95-626 P.L. 97-35	
Procurement of Information for the National Death Index	Department of Health and Human Services (Office of Asst. Secretary for Health-NCHS)			

Illinois Department of Public Health
Table A-39 Major Federal Funding Sources FY93
(continued)

Federal Program Title	Administering Federal Agency	Federal Act	Public Law	Match
Product Hazard and Injury Information (Death Certificates)	Consumer Product and Safety Commission (Division of Hazard and Injury Data Systems)			
AIDS - Prevention and Surveillance	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 301(a)	P.L. 95-626aa	
AIDS - Seroprevalence Studies	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 301(a)	P.L. 95-626aa	
Cervical Cancer Prevention and Control	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 301(a)	P.L. 78-410aa P.L. 95-626aa P.L. 99-159	
Data Based Cancer Intervention	Department of Health and Human Services, National Cancer Institute (Research)	Public Health Services Act, Sec. 301(a)	P.L. 78-410aa P.L. 95-626aa P.L. 99-159	
Social Security Enumeration at Birth	Department of Health and Human Services (Social Security Admin.)			
Drug Free Families with a Future	Department of Health and Human Services (ADAMHA, Office of Substance Abuse Prevention)	Public Health Services Act, Sec. 509F and 509G	P.L. 100-690	

Illinois Department of Public Health
Table A-39 Major Federal Funding Sources FY93
(continued)

Federal Program Title	Administering Federal Agency	Federal Act	Public Law	Match
Pregnancy Nutrition Surveillance System	Department of Health and Human Services (CDC)	PHS Act 317(K)(3) and 310(A)	P.L. 95-626	
Building State Capacity to Conduct Health Assessments	Department of Health and Human Services (ATSDR)	Sec. 104(I)(14)(15) of Comprehensive Environmental Response, Compensation, and Liability Act	P.L. 99-499aa P.L. 98-616	
Environmental Health Education for Physicians and Health Professionals	Department of Health and Human Services (ATSDR)	Sec. 104(I)(14)(15) of Comprehensive Environmental Response, Compensation, and Liability Act	P.L. 99-499 P.L. 98-616	
Laboratory Training Network	Department of Health and Human Services (CDC)	PHS Act Sec. 317(K)(3)	P.L. 95-626 P.L. 100-202	
Influenza Vaccine Demonstration	Department of Health and Human Services (HCFA)	Sec. 4071	P.L. 100-203	
Asbestos in Schools - AHERA Accreditation	U.S. Environmental Protection Agency - Office of Pesticides and Toxic Substances	Toxic Substance Control Sec. 28	P.L. 94-469	
State Office of Rural Health	Department of Health and Human Services (HCDA)	Public Health Services Act, Sec. 3385	P.L. 10-597	

Illinois Department of Public Health
Table A-39 Major Federal Funding Sources FY93
(continued)

Federal Program Title	Administering Federal Agency	Federal Act	Public Law	Match
Primary Health Care	Department of Health and Human Services (HCDA)	Public Health Services Act, Sec. 333(D)	P.L. 100-170	
Prenatal Smoking Cessation	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 301	P.L. 100-202	
Illinois State and Community Based Child Lead Poisoning	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 301 and 317A	P.L. 100-572	
Healthy Start	Department of Health and Human Services (HRSA)	Public Health Services Act, Title III, Part A, Sec. 301		
Breastfeeding Promotion	Department of Health and Human Services (HRSA)	Social Security Act, Title V, Sec. 502(a)(1)		
Lead Exposure	Department of Health and Human Services (ATSDR)	Sec. 104(15) Comprehensive Environmental Response Compensation and Liability Act of 1980	P.L. 99-499, P.L. 98-616	
HIV CARE Grant/AIDS	Department of Health and Human Services (HRD)	Public Health Services Act, Ryan White CARE Act, Title II	P.L. 101-381	20%
Enhancement to Asbestos Training Requirements	U.S. Environmental Protection Agency	Toxic Substance Control Act, Sec. 28	P.L. 94-469	25%

Illinois Department of Public Health
Table A-39 Major Federal Funding Sources FY93
(continued)

Federal Program Title	Administering Federal Agency	Federal Act	Public Law	Match
Modification of State Trauma Plan	Department of Health and Human Services (HRSA)	Public Health Services Act, as amended	P.L. 101-590	
Community Integrated Services System/Physician Participation	Department of Health and Human Services (HRSA)	Social Security Act, Title V, Sec. 502(a)(1)	P.L. 107-170	
CORE/Capacity Bldg. for Breast and Cervical Cancer	Department of Health and Human Services (CDC)	Public Health Services Act, Secs. 301(A) and 1507	P.L. 100-202	
Infant Immunization Initiative	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 317		
Compliance Testing of Sunlamp Products	Department of Health and Human Services (FDA)	Food, Drug and Cosmetic Act, Chapter V	P.L. 90-602	

The Department of Public Health receives federal funds via other agencies as follows:

Department of Public Aid:
- Title XX
- Indo-Chinese Refugee Program
- Social Services Block - Parents Too Soon; Rape; Early Periodic Screening, Diagnosis and Treatment.

Environmental Protection Agency:
- Federal Safe Drinking Water Act

Office of Education
- Summer Food Service Program
- Early Intervention for Infants and Toddlers

Abbreviations Used in Text:

ADAMHA	Alcohol, Drug Abuse and Mental Health Administration
AHERA	Asbestos Hazardous Emergency Response
ATSDR	Agency for Tonic Substances and Disease Registry
CDC	Centers for Disease Control
FDA	Food and Drug Adminstration
HCDA	Health Care Delivery and Assistance Bureau
HCFA	Health Care Financing Administration
HRSA	Health Resources and Services Administration
NCHS	National Center for Health Statistics
PHS	Public Health Service
aa	as amended

Illinois Department of Public Health

Table A-40 Projected Major Federal Funding Sources FY94

Federal Program Title	Administering Federal Agency	Federal Act	Public Law	Match
State-Based Diabetes Control Project	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 301(a)	P.L. 95-626 P.L. 95-224	
Food Inspection Program	Department of Health and Human Services (CDC)			
Disease Control Project Grant (Sexually Transmitted Diseases)	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 318, aa by the Communicable Disease Control Amendments of 1972 and 1976.	P.L. 92-449; P.L. 92-317; P.L. 95-626	
Disease Control Project Grant (Immunization)	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 317, aa by the Communicable Disease Control Amendments of 1972 and 1976.	P.L. 92-449; P.L. 92-317; P.L. 95-626	
Vital Records Component of Cooperative Health Statistics System	Department of Health and Human Services (CDC)			
State Health Care Providers Survey Certification	Department of Health and Human Services (HCFA)	Social Security Act of 1965, Title XVIII, Part A	P.L. 89-97 aa by P.L.S. 90-248, 92-603, 93-233, 94-182 and 94-437	

Illinois Department of Public Health
Table A-40 Projected Major Federal Funding Sources FY94
(continued)

Federal Program Title	Administering Federal Agency	Federal Act	Public Law	Match
Special Supplemental Food Program for Women, Infants and Children	Department of Agriculture (Food and Nutrition Service)	Child Nutrition Act of 1966, Section 17	aa P.L. 92-433; aa P.L. 94-105 aa P.L. 95-627 P.L. 96-499 P.L. 98-473 P.L. 99-190 P.L. 99-500 P.L. 99-591	
Commodity Supplemental Food Program	Department of Agriculture (Food and Nutrition Services)	Agriculture and Consumer Protection Act of 1973; Food and Agriculture Act of 1977	aa P.L. 93-86 P.L. 95-113 97-98 98-92 99-198 99-500 99-591	
Pesticide Use and Marketing Enforcement	U.S. Environmental Protection Agency and Illinois Department of Agriculture	The Federal Insecticide, Fungicide, and Rodenticide Act, 7 U.S.C. 135, et. seq.	P.L. 92-516 aa P.L. 94-140 aa P.L. 95-396	15%
Health Programs for Refugees	Department of Health and Human Services (CDC)	Immigration and Nationality Act, Section 412(c)(3)	P.L. 96-212 aa P.L. 97-363 P.L. 99-605	

Illinois Department of Public Health

Table A-40 Projected Major Federal Funding Sources FY94

(continued)

Federal Program Title	Administering Federal Agency	Federal Act	Public Law	Match
Family Planning - Title X	Department of Health and Human Services (PHS)	Public Health Service Act, Title X, Section 1001	P.L. 95-613	Some. Federal funds cannot be 100%
TB Control Project	Department of Health and Human Services (CDC)	Public Health Services Act, Section 317	P.L. 97-35 aa P.L. 98-555	
Maternal and Child Health Block Grant	Department of Health and Human Services PHS, HRSA, Bureau of Maternal and Child Health Services	Social Security Act, Title V	P.L. 97-35	3/7 (42.86%)
Preventive Health and Health Services Block Grant	Department of Health and Human Services (CDC)	Public Health Services Act, Title XIX, Part A	P.L. 97-35 P.L. 98-555	
Behavioral Risk Factor Surveillance	Department of Health and Human Services (CDC)	Public Health Services Act 301(a)	P.L. 95-626 P.L. 97-35	
Procurement of Information for the National Death Index	Department of Health and Human Services (Office of Asst. Secretary for Health-NCHS)			

Illinois Department of Public Health
Table A-40 Projected Major Federal Funding Sources FY94
(continued)

Federal Program Title	Administering Federal Agency	Federal Act	Public Law	Match
Product Hazard and Injury Information (Death Certificates)	Consumer Product and Safety Commission (Division of Hazard and Injury Data Systems)			
AIDS - Prevention and Surveillance	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 301(a)	P.L. 95-626aa	
AIDS - Seroprevalence Studies	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 301(a)	P.L. 95-626aa	
Cervical Cancer Prevention and Control	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 301(a)	P.L. 78-410aa P.L. 95-626aa P.L. 99-159	
Data Based Cancer Intervention	Department of Health and Human Services, National Cancer Institute (Research)	Public Health Services Act, Sec. 301(a)	P.L. 78-410aa P.L. 95-626aa P.L. 99-159	
Social Security Enumeration at Birth	Department of Health and Human Services (Social Security Administration)			
Drug Free Families with a Future	Department of Health and Human Services (ADAMHA, Office of Substance Abuse Prevention)	Public Health Services Act, Sec. 509F and 509G	P.L. 100-690	

Illinois Department of Public Health
Table A-40 Projected Major Federal Funding Sources FY94
(continued)

Federal Program Title	Administering Federal Agency	Federal Act	Public Law	Match
Pregnancy Nutrition Surveillance System	Department of Health and Human Services (CDC)	PHS Act 317(K)(3) and 310(A)	P.L. 95-626	
Building State Capacity to Conduct Health Assessments	Department of Health and Human Services (ATSDR)	Sec. 104(I)(14)(15) of Comprehensive Environmental Response, Compensation, and Liability Act	P.L. 99-499aa P.L. 98-616	
Environmental Health Education for Physicians and Health Professionals	Department of Health and Human Services (ATSDR)	Sec. 104(I)(14)(15) of Comprehensive Environmental Response, Compensation, and Liability Act	P.L. 99-499 P.L. 98-616	
Laboratory Training Network	Department of Health and Human Services (CDC)	PHS Act Sec. 317(K)(3)	P.L. 95-626 P.L. 100-202	
Influenza Vaccine Demonstration	Department of Health and Human Services (HCFA)	Sec. 4071	P.L. 100-203	
Asbestos in Schools - AHERA Accreditation	U.S. Environmental Protection Agency (Office of Pesticides and Toxic Substances)	Toxic Substance Control Sec. 28	P.L. 94-469	
State Office of Rural Health	Department of Health and Human Services (HCDA)	Public Health Services Act, Sec 3385	P.L. 10-597	
Primary Health Care	Department of Health and Human Services (HCDA)	Public Health Services Act, Sec. 333(D)	P.L. 100-170	

Illinois Department of Public Health
Table A-40 Projected Major Federal Funding Sources FY94
(continued)

Federal Program Title	Administering Federal Agency	Federal Act	Public Law	Match
Prenatal Smoking Cessation	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 301	P.L. 100-202	
Illinois State and Community Based Child Lead Poisoning	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 301 and 317A	P.L. 100-572	
Healthy Start	Department of Health and Human Services (HRSA)	Public Health Services Act, Title III, Part A, Sec. 301		
Breastfeeding Promotion	Department of Health and Human Services (HRSA)	Social Security Act, Title V, Sec. 502(a)(1)		
Lead Exposure	Department of Health and Human Services (ATSDR)	Sec. 104(15) Comprehensive Environmental Response Compensation and Liability Act of 1980	P.L. 99-499, P.L. 98-616	
HIV CARE Grant/AIDS	Department of Health and Human Services (HRD)	Public Health Services Act, Ryan White CARE Act, Title II	P.L. 101-381	20%
Enhancement to Asbestos Training Requirements	U.S. Environmental Protection Agency	Toxic Substance Control Act, Sec. 28	P.L. 94-469	25%
Modification of State Trauma Plan	Department of Health and Human Services (HRSA)	Public Health Services Act, as amended	P.L. 101-590	

Illinois Department of Public Health

Table A-40 Projected Major Federal Funding Sources FY94

(continued)

Federal Program Title	Administering Federal Agency	Federal Act	Public Law	Match
Community Integrated Services System/Physician Participation	Department of Health and Human Services (HRSA)	Social Security Act, Title V, Sec. 502(a)(1)	P.L. 107-170	
CORE/Capacity Bldg. for Breast and Cervical Cancer	Department of Health and Human Services (CDC)	Public Health Services Act, Secs. 301(A) and 1507	P.L. 100-202	
Infant Immunization Initiative	Department of Health and Human Services (CDC)	Public Health Services Act, Sec. 317		
Compliance Testing of Sunlamp Products	Department of Health and Human Services (FDA)	Food, Drug and Cosmetic Act, Chapter V	P.L. 90-602	

The Department of Public Health receives federal funds via other agencies as follows:

Department of Public Aid:
- Title XX
- Indo-Chinese Refugee Program
- Social Services Block - Parents Too Soon; Rape; Early Periodic Screening, Diagnosis and Treatment.
- Teen Parent Employment Training

Environmental Protection Agency:
- Federal Safe Drinking Water Act

Office of Education
- Summer Food Service Program
- Early Intervention for Infants and Toddlers

Abbreviations Used in Text:

ADAMHA	Alcohol, Drug Abuse and Mental Health Administration
AHERA	Asbestas Hazardous Emergency Response
ATSDR	Agency for Tonic Substances and Disease Registry
CDC	Centers for Disease Control
HCDA	Health Care Delivery and Assistance Bureau
HCFA	Health Care Financing Administration
HRD	Health Resources Development
HRSA	Health Resources and Services Administration
NCHS	National Center for Health Statistics
PHS	Public Health Service
aa	as amended

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